State Innovation Model

Operational Plan

For Health System Innovation

Prepared by the State of Vermont

For the Centers for Medicare and Medicaid Services

July 31, 2013

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Introduction Vermont State Innovation Model Operational Plan

This document is intended to inform readers, including reviewers from the federal Centers for Medicare and Medicaid Services (CMS), of Vermont's plans to utilize State Innovation Model (SIM) grant funds to support improvements in the state's health care system. Vermont was awarded $45 million under the SIM program over a four-year period. Grants funds will be used to accomplish three major project aims:

- Improve care;
- Improve population health; and
- Reduce health care costs.

Section A of this plan describes *how* Vermont will manage this project, and how high-level support from the executive and legislative branches, as well as from major stakeholders, will be assured. Section B describes *what* Vermont will manage through this project – expansion and integration of care models, payment models and health information technology, on a statewide and multi-payer basis, to support a high performance health system.

In the State Health Care Innovation Plan submitted with our SIM grant application, we said "Vermont's strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance." We are implementing this strategy in a comprehensive manner – across acute and long-term care providers, across mental and physical health and across public and private payers. Our project is aimed at assuring a health care system that is affordable and sustainable through coordinated efforts to lower overall costs and improve health and health care for Vermonters, throughout their lives. This comprehensive approach has the potential to provide a model for how system-wide change of this sort can be successfully organized, designed and implemented.

Our goals for this project include:

- To enhance the level of accountability for cost and quality outcomes among provider organizations;

- To create a health information network that supports the best possible care management and assessment of cost and quality outcomes;
- To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
- To assure accountability for outcomes from both the public and private sectors; and
- To create commitment to change and synergy between public and private culture, policies and behavior.

We have structured our operational plan to align our efforts with these goals. Sections C through T of this plan respond to specific questions posed by CMS regarding operational aspects of the Vermont SIM project. In its entirety, the Operational Plan is intended to provide a description of how Vermont is approaching this initiative, our progress to date and our plans for the next 3 ½ years of the project.

Section A Governance, Management Structure and Decision-making Authority

This section provides information regarding Vermont's governance and management structure for the SIM project, as well as clarification of the role of the Governor's Office in overseeing the project.

Question 1. Does the SIM initiative have sufficient executive support from State government, from the Governor, the legislative branch of the State and the private sector – with workable governance and management resources and processes and adequate authority to make decisions on the innovation model, project design and implementation?

Vermont has designed structures for governance and management of the SIM project to ensure appropriate representation of private sector SIM partners as well as the multiple state agencies and departments involved in the project. The structure includes a strong linkage with the Governor's Office, shared public-private governance and an effective project management organization.

Vermont's project structure will reinforce linkages with key related state and federally-supported initiatives, such as the state's dual eligibles project and the state's primary care medical homes initiative. Public-private governance and private sector involvement in developing deliverables under the project also will reinforce coordination between grant-funded activities and related activities occurring in the private sector. We believe our project structure will allow us to:

- Effectively coordinate across these initiatives;
- Incorporate meaningful input from and communication with all involved; and
- Provide for clear project direction and effective decision-making.

This project is consistent with the legislative authority granted to Vermont's executive branch and the Green Mountain Care Board to undertake comprehensive health care payment and delivery system reform activities. Project leaders will provide updates to legislative leadership

throughout the life of the project to assure that the legislature is appropriately informed of our progress toward project aims.

Governor's Office Engagement

Governor Shumlin has made health care reform his top priority. While the Governor has an overall agenda of creating a unified, universal system of quality health care separated from employment and funded publicly, he has recognized consistently that cost control and improved outcomes must lead: without them, simply paying for the system in a different way will do little to achieve lasting and sustainable reform. The Governor included cost-containment and improving the value of health care as the central components of Act 48. This was his legislative priority in the first session of his first term and was passed by the Vermont General Assembly that year. This legislation created the Green Mountain Care Board (GMCB) and the State's Director of Health Care Reform and set a clear executive and legislative agenda for health care payment and delivery system reform. The Green Mountain Care Board is an independent five-member board appointed by the Governor with confirmation of appointments through the State Senate. The Director of Health Care Reform works within the Office of the Secretary of Administration, functioning essentially as an extension of the Governor's staff.

The Governor's Office has been heavily engaged in planning for Vermont's SIM initiative. The Governor authorized a joint application for the grant by the Agency of Human Services and the Green Mountain Care Board. He has met at regular intervals with the SIM Core Team (the top leadership of the project), has provided direct guidance to the group, and has provided indirect guidance through his Chief of Staff and Secretary of Administration. The Governor announced the SIM grant award via press release on February 21, 2013 and at a March, 27, 2013 press conference highlighted the grant as one example of how his overall reform agenda is progressing. In addition, the Governor consistently speaks publicly about the importance of cost containment and moving from a fee-for-service system to a payment system based on value. See press releases in the Appendix under Section A Artifacts. The Governor also meets on a periodic basis with key stakeholders who are central to carrying out the SIM project and participants on the SIM Steering Committee.

The Governor's Office has directed the SIM Core Team to organize the project management structure to:

- Include private sector partners in all levels of project decision-making;

- Integrate the State's demonstration project for individuals who are dually eligible for Medicare and Medicaid within the SIM governance structure and decision-making process to ensure that these efforts are aligned and providing consistent incentives for change;
- Provide for strong project management and clear decision-making related to three dimensions of potential project impact –
    - Distribution of SIM funds and other resources
    - Changes in state policy necessary to support payment and delivery system innovation
    - Positive influence on private sector innovation

The Governor's directives will be implemented through the project governance and management structures described below. The Governor and his top managers of health reform (his Chief of Staff, Secretary of Administration and Director of Health Care Reform) will continue to be closely involved and frequently consulted in a meaningful manner, providing clear oversight throughout the life of the project. The Governor will meet with the SIM Core Team monthly to hear progress updates and his top managers will meet more frequently with project managers and leaders. The Director of Health Care Reform will serve as a member of the Core Team.

In addition, the Governor will be assigning Anya Rader Wallack, who has chaired the Green Mountain Care Board since its inception, to a new role as Chair of the Core Team. Wallack announced in May that she would be stepping down by September as GMCB Chair. In her new role, she will provide high-level leadership to the Core Team, strategic guidance to the overall project and direct reporting to the Governor on project progress and outcomes. Wallack has been deeply involved in Vermont's SIM efforts to date. She was a primary force behind the State's SIM application and State Health Care Innovation Plan. She has served, since the grant award, as the de facto Project Director for SIM. Wallack also has been an active member of the State's Dual Eligibles Steering Committee. Wallack's new role will be finalized through a contract with the Governor's Office and is expected to begin in late August, after a break from her duties at the Green Mountain Care Board.

The Chair and other members of the Core Team will hire a Project Director who will be responsible for day-to-day management and coordination of staff and contractors working under the grant. The Chair of the Core Team will act as liaison between the Core Team and the Project Director, ensure that the Core team is appropriately informed of project activities and issues and work with the Project Director to make certain the strategic direction set by the Core Team, guided by the SIM Steering Committee, is implemented.

Project Governance

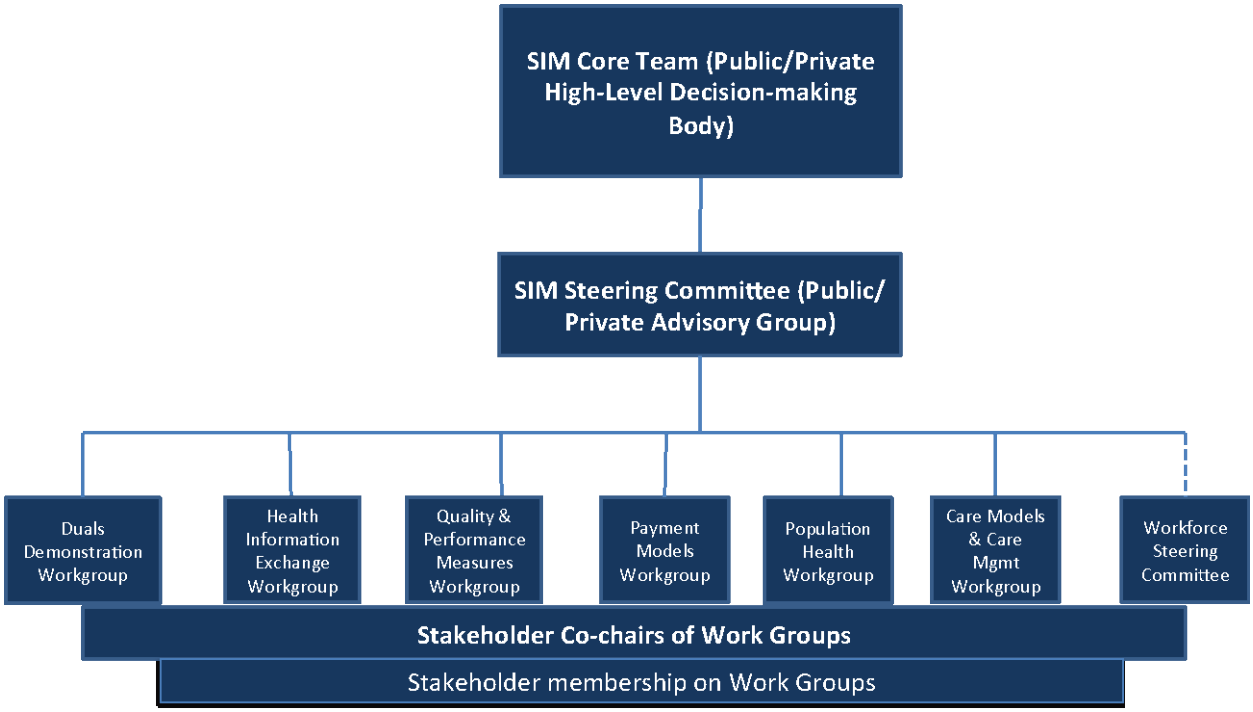
The Vermont SIM Project, per the direction of the Governor, will include oversight of the State's dual eligibles financial alignment demonstration project. Vermont's health reform leaders recognize that efforts to better coordinate both care delivery and health care financing for Vermonters who are elderly and/or have chronic illnesses or disabilities is paramount. These populations experience some of the greatest gaps in care, diminished quality of services and potentially avoidable costs of care of all Vermonters. Inclusion in the SIM project of interventions aimed at these populations is therefore critical regardless of the State's decision about the fiscal prudence of pursuing the duals demonstration, which will depend in large part on negotiation of terms and conditions of the demonstration with CMS.

The SIM project will be governed through a structure that integrates public and private oversight and consideration of the dually-eligible population at three levels:

- The Core Team
- The Steering Committee
- Six Work Groups

This structure is illustrated in the organizational chart below. The purpose and composition of each of these levels of governance also is described below.

State Innovation Model Project Governance



The Core Team

This group will provide overall direction to the State Innovation Model project, synthesize and act on guidance from the Steering Committee, set project priorities and help resolve any conflicts within the project initiatives. Members of the Core Team are:

Anya Rader Wallack, Ph.D., Chair

Anya Rader Wallack has been chair of the Green Mountain Care Board for almost two years. The GMCB regulates hospital budgets, health insurer rates and major health care capital expenditures. It also has the authority to implement all-payer rate-setting. The GMCB also has broad responsibility for multi-payer payment reform efforts in Vermont, and has authorized pilot projects that test alternatives to fee-for-service payment. Prior to chairing the GMCB Anya served as Governor Shumlin's Special Assistant for Health Care Reform and had primary responsibility for early implementation of his health reform agenda, including Act 48 of 2011, which created the framework for a single payer system in Vermont and created the GMCB. Wallack served in a similar role for Governor Howard Dean in the 1990s and has consulted with numerous states, non-profits and provider organizations on issues related to state-based health care reform.

Robin Lunge, Director of Health Care Reform

Robin Lunge has been Director of Health Care Reform for the Governor since July 1, 2011, after the passage of Act 48 in 2011. In her first position with the Governor, she assisted Anya Rader Wallack in writing and achieving passage of Act 48. Prior to the Governor's election, she served for approximately eight years as the lead staff attorney for the Vermont legislature on health care reform and health and human services policy, which involved supporting multiple legislative committees on these issues and authoring all major health reform legislation during that time. Lunge also worked at the Center on Budget and Policy Priorities in Washington D.C. as a senior policy analyst on welfare and poverty issues. Since joining the Governor's team as the Director of Health Care Reform, she is responsible for moving three major bills through the legislature in order to implement Act 48 and the Affordable Care Act. In this role, she oversees health reform efforts across the executive branch, including Vermont Health Connect, Vermont's state-based health benefit marketplace; Vermont's health information technology upgrades within state government; and Vermont's planning efforts to move to a unified, universal system.

Lisa Ventriss, President, Vermont Business Roundtable

Lisa Ventriss is President of the Vermont Business Roundtable. The Roundtable is a non-partisan, non-political, public affairs organization comprised of 115 CEOs from among the state's most successful private sector and not-for-profit employers. Through thoughtful policy research and analysis, collaboration and advocacy, the Roundtable seeks to leverage the entrepreneurial capital of its members to benefit the welfare of all Vermonters on economic, social and environmental matters. The Roundtable is a member of Partners for Health Reform, a multi-stakeholder group that includes representation of payers, providers and the business community concerned with assuring the success of health reform.

Doug Racine, Secretary of Human Services

Doug Racine oversees the largest agency of Vermont state government, which includes the Departments of Health; Mental Health; Disabilities, Aging and Independent Living; Children and Families; and Corrections. The agency also includes the Department of Vermont Health Access, which runs the state's Medicaid program. Racine is a former seven term State Senator, where he held various positions, including President pro tempore and chair of the Health and Welfare Committee. He also served three terms as Lieutenant Governor under Governor Howard Dean. In his previous roles, he worked closely with then-Senator Peter Shumlin in developing Vermont's earlier health care reform initiatives.

Al Gobeille, incoming Chair of the Green Mountain Care Board

Al Gobeille is the incoming chair of the GMCB, and has served as a member of the Board since October of 2011. He owns and operates a hospitality business, which operates three restaurants and a cruise business on Lake Champlain. He has previously served on the board of the Visiting Nurse Association of Chittenden and Grand Isle Counties and was a member of the state's Payment Reform Advisory Council. Gobeille is currently a member of the Shelburne Town Selectboard, past chair of the Burlington Business Association, members of the Champlain Valley Exposition board, and a member of the Lake Champlain Regional Chamber of Commerce board.

Mark Larson, Commissioner of the Department of Vermont Health Access

Mark Larson is the Commissioner of the Department of Vermont Health Access (DVHA). The Department administers Vermont's public health care programs. It also is responsible for the development and implementation of Vermont's health insurance exchange and Green Mountain Care, Vermont's universal health care program. Prior to being appointed Commissioner by Governor Shumlin, Larson was a member of the Vermont House of Representatives serving as the Chair of the House Health Care Committee. He also previously served as Vice Chair of the House Appropriations Committee and Co-Chair of the Vermont Commission on Health Care Reform.

Susan Wehry, M.D., Commissioner of the Department of Disabilities, Aging, and Independent Living

Susan Wehry is Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL). Wehry is a board-certified geriatric psychiatrist and advocate for seniors and persons with disabilities who has educated physicians, nurses, medical students, ombudsmen, policy makers and direct care workers from Alaska to Louisiana. She has assisted the Centers for Medicare and Medicaid Services in the development of national web-casts on mental health needs and individualized care planning in nursing homes.

Paul Bengtson, CEO, Northeastern Vermont Regional Hospital

Paul Bengtson has been CEO of Northeastern Vermont Regional Hospital, located in one of the most rural areas of Vermont, since 1986. The hospital owns and manages several rural health clinics in Vermont's Northeast Kingdom and works closely with Northern Counties Health Care, a federally-qualified health center with a dominant presence in the area. Bengston began his professional career in inner New York City, working in housing project health maintenance clinics. He also worked in large teaching hospitals in NYC in the 1970s. He is chair-elect of the American Hospital Association Governing Council for Small or Rural Hospitals and a member of the Green Mountain Care Board General Advisory Council.

The Steering Committee

The Steering Committee will inform, educate and guide the Core Team in all of the work planned under the SIM grant. In particular, the group will guide the Core Team's decisions about investment of project funds, necessary changes in state policy and how best to influence desired innovation in the private sector. See below for a list of Steering Committee members.

The membership of the Steering Committee brings a broad array of perspectives from multiple agencies within state government, and multiple groups and organizations from outside state government. The Steering Committee will include at least one of the co-chairs of Work Groups (described below), who will be expected to report on the recommendations of those work groups in specific subject areas defined in their charters.

Work Groups

Six work groups will be established as part of the SIM/Duals Project. They are:

- Payment Models Work Group
- Care Models and Care Management Work Group
- Duals Demonstration Work Group
- Health Information Exchange Work Group
- Quality and Performance Measures Work Group
- Population Health Work Group

In addition, the Agency of Administration is establishing a Health Care Workforce Work Group through Executive Order (signed today) that will lead workforce-related efforts under the grant.

Work groups will have specific charters related to their scope of work and expected deliverables. Deliverables will take the form of recommendations to the Steering Committee and Core Team. The general scope of each of the work groups is described below. Members of all Work Groups will be expected to be active, respectful participants in meetings; to consult between meetings with constituents, clients, partners and stakeholders, as appropriate, to gather input on specific questions and issues; and to alert SIM leadership about any actual or perceived conflicts of interests that could impede their ability to carry out their responsibilities. Work groups will be responsible not only for their own scope of work but, to a significant degree, for coordinating with other work groups to develop joint recommendations to the Steering Committee on cross-cutting issues related to care models, payment models and quality measures.

Two of these groups, the Payment Models Work Group and the Quality and Performance Measures Work Group, are reconstituted from groups that have been working to date with DVHA and the GMCB to develop standards and quality measures for the commercial and Medicaid ACO models.

The membership of the Steering Committee and co-chairs of the Work Groups are listed below.

State Innovation Model Project Leadership

Core team

Anya Rader Wallack, Ph.D., Chair

Paul Bengtson, CEO, Northeastern Vermont Regional Hospital

Al Gobeille, incoming Chair of the Green Mountain Care Board

Mark Larson, Commissioner of the Department of Vermont Health Access

Robin Lunge, Director of Health Care Reform

Doug Racine, Secretary of Human Services

Lisa Ventriss, President, Vermont Business Roundtable

Susan Wehry, M.D., Commissioner of the Department of Disabilities, Aging, and Independent Living

Steering Committee

John Barbour, Executive Director, Champlain Valley Area Agency on Aging (Invited)

Susan Barrett, Director of Vermont Public Policy, Bi-State Primary Care

Stephanie Beck, Director of Health Care Operations, Compliance, and Improvement, Agency of Human Services

Bob Bick, Director of Mental Health and Substance Abuse Services, Howard Center for Mental Health (Invited)

Harry Chen, M.D., Commissioner of the Department of Health

Peter Cobb, Director, Vermont Assembly of Home Health and Hospice Agencies

Elizabeth Cote, Area Health Education Centers Program

Elizabeth Davis, R.N., MPH, Consultant on Long Term Services and Supports (Invited)

Susan Donegan, Commissioner of the Department of Financial Regulation

Kate Duffy, Commissioner, Department of Human Resources

Paul Dupre, Commissioner of the Department of Mental Health

Nancy Eldridge, Cathedral Square and SASH Program

John Evans, President and CEO, Vermont Information Technology Leaders

Catherine Fulton, Executive Director, Vermont Program for Quality in Health Care

Don George, President and CEO, Blue Cross Blue Shield of Vermont

Bea Grause, President, Vermont Association of Hospital and Health Systems

Dale Hackett, Consumer Advocate

Paul Harrington, President, Vermont Medical Society

Debbie Ingram, Vermont Interfaith Action

Craig Jones, M.D., Director of the Vermont Blueprint for Health

Trinka Kerr, Health Care Ombudsman

Deborah Lisi-Baker, Disability Policy Expert

Bill Little, Vice President, MVP Health Care

Jackie Majoros, Long-term Care Ombudsman

Todd Moore, CEO, OneCare Vermont

Ed Paquin, Disability Rights Vermont

Laura Pelosi, Vermont Health Care Association

Judy Peterson, Visiting Nurse Association of Chittenden and Grand Isle Counties (Invited)

Allan Ramsay, M.D., Member of the Green Mountain Care Board

Paul Reiss, M.D., Executive Director, Accountable Care Coalition of the Green Mountains

Howard Schapiro, M.D., Interim President of the University of Vermont Medical Group Practice

Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services

Philene Taormina, AARP-Vermont (Invited)

Dave Yacavone, Commissioner of the Department for Children and Families

Work Group Chairs

Payment Models

Don George, President and CEO, BCBSVT

Stephen Rauh, Health Policy Consultant and Member of GMCB Advisory Board, (Invited)

Care Models and Care Management

Bea Grause, President, Vermont Association of Hospitals and Health Systems

Susan Barrett, Director of Vermont Public Policy, Bi-state Primary Care

Health Information Exchange

Simone Rueschemeyer, Behavioral Health Network (Invited)

Matthew Watkins, M.D., Cardiologist at Fletcher Allen Health Care (Invited)

Dual Eligibles

Deborah Lisi-Baker, Disability Policy Expert

Judy Peterson, Visiting Nurse Association of Chittenden and Grand Isle Counties

Quality and Performance Measures

Catherine Fulton, Executive Director, Vermont Program for Quality in Health Care

Laura Pelosi, Vermont Health Care Association (Invited)

Population Health Management

Harry Chen, M.D., Commissioner of the Department of Health

Karen Hein, M.D., Member of the Green Mountain Care Board

The charge to each of the Work Groups is described below.

Payment Models Work Group

This group will build on the work of the ACO standards work group to date and:

- Continue to develop and recommend standards for the commercial shared savings ACO (SSP-ACO) model
- Develop and recommend standards for the Medicaid SSP-ACO model
- Develop and recommend standards for both commercial and Medicaid episode of care models
- Develop and recommend standards for Medicaid pay-for-performance models
- Review the work of the duals demonstration work group on payment models for dual eligibles
- Recommend mechanisms for assuring consistency and coordination across all payment models

Care Models and Care Management Work Group

This group will examine current or planned care management programs and care delivery models including:

- The Blueprint for Health Advanced Primary Care Medical Home, including Community Health Teams

- The Support and Services at Home (SASH) program
- Care management programs of the commercial payers
- Care management programs of Medicaid
- Care models or care management implemented or contemplated by Medicare ACOs
- Care models or care management contemplated as part of the duals demonstration
- Large-scale population-based care or health improvement models that might complement or integrate with the above

The group will recommend mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service delivery, financial incentives, quality measurement or other key model or program components. The goal will be to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.

Duals Demonstration Work Group

This group will build on the extensive work of the duals demonstration steering committee. The group continue to develop recommendations for the design of the state's financial alignment demonstration regarding:

- A care model or models for dually-eligible Vermonters that improves beneficiary service and outcomes
- Provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve dually-eligible populations
- Quality measures to be used to evaluate provider and overall project performance
- A financial model that allows for an assessment of the potential costs, benefits and risks of the project for the state, providers and beneficiaries
- Management structures necessary to administer the project at both the state and provider levels

The group also will recommend mechanisms for assuring alignment of the duals demonstration with other payment reform initiatives, including any flexibility from the federal government that is necessary to achieve such alignment. These recommendations will support the state's assessment of whether to pursue the demonstration as details of the federal terms and conditions are identified.

Health Information Exchange Work Group

This group will:

- Identify the desired characteristics and functions of a high-performing statewide information technology system.
- Explore and recommend technology solutions to achieve SIM's desired outcomes.
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
    - support for enhancements to EHRs and other source data systems
    - expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers
    - implementation of and/or enhancements to data repositories
    - implementation of and/or enhancements to data integration platform(s)
    - development of advanced analytics and reporting systems

The group also will advise the development of the state's health information technology plan with regard to the above activities and expenditures.

The SIM HIE work group will be responsible for the following deliverables:

- Recommendations to the Steering Committee regarding the HIE work plan.
- Recommendations on expenditure of SIM funds to support HIT investments.
- Recommendations on coordination of HIT/HIE related efforts across various agencies and organizations.
- Recommendations on prioritization of new initiatives such as EHR installations, interfaces, and other investments.

Quality and Performance Measures Work Group

This group will build on the work of the ACO Quality and Performance Measures Work Group, and will recommend standardized measures that will be used to:

- Evaluate the performance of Vermont's payment reform models relative to state objectives;
- Qualify and modify shared savings, episodes of care, pay for performance, and health home payments; and
- Communicate performance to consumers through public reporting.

The overarching goal of quality and performance measurement is to focus health care reform and quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population.

The work group's deliverables will include recommendations on consolidated and standardized sets of all-payer quality and performance measures to be used to indicate improvements in performance, monitor adherence to quality standards, and qualify and modify payments to providers or provider organizations. When possible, the focus will be on nationally accepted measures that can be benchmarked. As needed, the work group will make recommendations regarding data resources for proposed measures, troubleshooting measurement barriers, and supporting measurement issue resolution. Performance measures will be reviewed on at least an annual basis, and will be revised, retired or replaced as appropriate.

Population Health Work Group

This group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

Project Management

The Vermont State Innovation Model Project will be managed through a combination of state personnel (existing and to be hired under the grant) and an outside vendor with project management expertise. The entire management structure will be overseen by the SIM Project Director, who will report directly to the SIM/Duals Core Team. The Project Director will have responsibility for coordinating all aspects of project management. The Project Director will oversee a team of high-level managers from within five state departments and agencies (the Green Mountain Care Board, the Agency of Human Services, DVHA, the Department of

Disabilities, Aging and Independent Living and the Department of Mental Health) along with two grant and fiscal managers, augmented by the project management vendor. Staff from within the five agencies and departments will be assigned to provide support to the work groups, also augmented by the project management vendor.

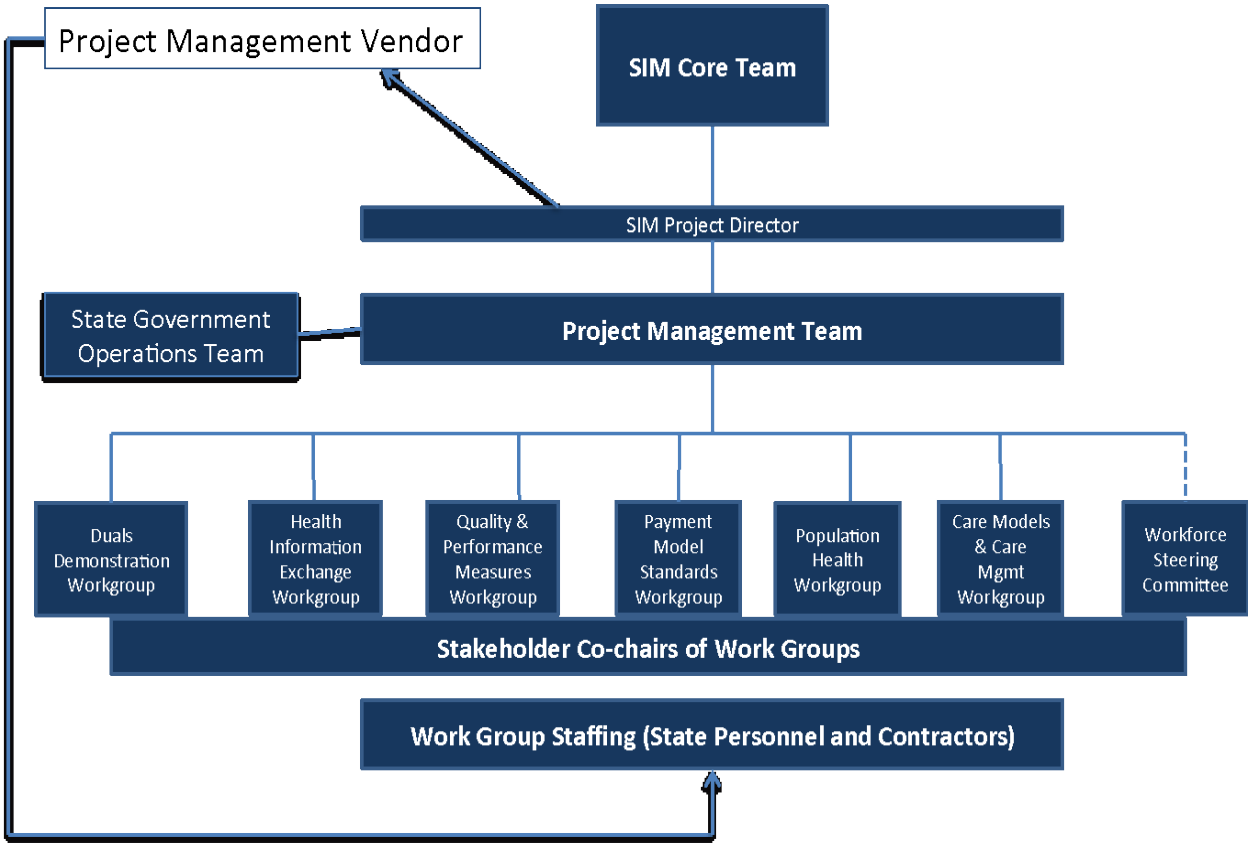
An RFP for project management was released by the Green Mountain Care Board in June. Nine bids were received in response to that RFP on July 16 and were reviewed by an interagency team with contractor selection likely by early August and a contract likely in place by mid-August. The vendor selected will provide logistical support to the entire project, and manage tracking of timelines and deliverables.

Work Groups will produce deliverables according to specific charters that are reviewed by the Steering Committee and the Core Team. Work Groups will be expected to report regularly to the Steering Committee on their progress and to do so in an agreed-upon format approved by the Project Director. Work Groups may need additional support from contractors with subject area expertise or analytic capabilities necessary to complete the Work Group's tasks. These contracts will be coordinated through the Project Director to maximize their value and avoid duplication of effort. Three of the work groups pre-existed this project management structure and have had consultants supporting their work to date. These contracts will continue to support the reconstituted work groups under SIM:

- Payment models (Bailit Health)
- Quality measures (Bailit health)
- Dual Eligibles Steering Committee (Pacific Health Group and Bailit Health)

The organizational chart below illustrates the management and staffing structure for the SIM project.

Management and Staffing of the State Innovation Model Project



The Government Operations Team

The Government Operations Team will be a group of state government managers and staff with responsibility for evaluating the feasibility of implementation of project-related initiatives and developing operational and financial plans to support project activities as they relate to state government. The team also will coordinate project activities with ongoing functions of state departments and agencies, including functions of the Agency of Human Services and regulatory processes of the Green Mountain Care Board. The Government Operations Team will focus specifically on assuring that SIM initiatives are consistent with all federal funding and Medicaid rules and funding restrictions, and are feasible in terms of operational requirements, including information system capacity. The team also will function as a strong connection between the SIM effort and:

- the Agency of Human Services Health Service Enterprise, which governs health benefit marketplace build-out and other major health information technology initiatives within the Agency;
- related health and human services programs administered by the Agency, for which there may be programmatic, operational or beneficiary experience impacts from the SIM project.

Mechanisms to Coordinate Private and Public Efforts around Key Test Model Elements

Coordination of private and public sector efforts will be essential to the success of Vermont's SIM project. The graphic below was used at the first meeting of the SIM steering committee to illustrate the importance of coordination across these sectors. The SIM project will provide a forum for coordinating policy and resources to support development of the organizations, technology and financing necessary to achieve the shared public/private goals articulated in our State Health Care Innovation Plan: development of a high performance health care system for Vermont.

The Governor has made clear that he believes coordination is essential among public and private efforts to increase efficiency and quality in Vermont's health care system. A small and rural state must achieve economies of scale and other efficiencies to simultaneously provide the highest-quality care, improve health outcomes and meet the service needs of rural populations.

The primary mechanism for coordination of public and private efforts related to Vermont's testing models will be the State Innovation Model Governance Structure. The Core Team will provide overall project leadership and will have as one of its goals maximizing alignment between SIM activities and current and future private sector activity that is related to or in support of project goals. Through the Steering Committee the Core Team will receive regular updates on private sector initiatives and guidance about how best to coordinate with project activities. In addition, each of the Work Groups will develop work products with an eye toward maximizing synergy between public and private sector activities. This effort already has borne fruit: the SIM Steering Committee on July 18 reviewed recommendations of the ACO Standards Work Group on key components of a commercial shared savings ACO design. These recommendations were developed by both state and private sector representatives, with an explicit goal of aligning across both sectors.

Additional coordination of private and public sector activities will occur through the regulatory authority of GMCB, which offers a clear nexus with hospital budgets, certificates of need, health insurer rates (including rates for plans offered through Vermont Health Connect) and benefit designs authorized for Vermont Health Connect. In general, Vermont Health Connect provides a very rare opportunity for unified policy approaches across a state's entire small group and individual health insurance marketplaces. Section G of this plan provides more information on the policy and regulatory levers available to support achievement of the goals of this project.

Finally, the state's effort to design and implement the shared savings ACO model includes a limited number of ACOs, one of which includes a preponderance of the providers in the state. Vermont does not have exclusive provider networks that are common in many other states. Most providers are not part of an exclusive network and serve commercial, Medicare and Medicaid patients. We have no major private sector managed care presence in the state, for commercial or Medicaid business.

Vermont's SIM Project is well-aligned with existing Legislative and Executive Authority. Act 48 of 2011 provided very broad responsibility and authority for the executive branch and the Green Mountain Care Board to implement health system innovation, including:

- Expansion of the pre-existing Blueprint for Health Program (the state's far-reaching advanced primary care medical home initiative)

- Expansion of the state's payment reform pilot activities
- General authority for the GMCB to implement payment reform and all-payer payment methodologies
- Creation of Vermont Health Connect as a single marketplace for Vermont's small and individual health insurance markets and a single "gateway" to health insurance for those markets and for Vermonters who are eligible for Medicaid coverage
- Consolidation and strengthening of regulatory processes relating to hospital budgets, major capital expenditures and health insurer rates under the GMCB

Prior legislative action had given the Agency of Human Services and the Department of Vermont Health Access authority to implement the Blueprint and pursue a federal waiver for the initiative, as well as authority to pursue the state's "Global Commitment" and "Choices for Care" waivers under section 1115 of the Social Security Act. Also, the Legislature in 2011 gave general authority for the Agency to pursue the Dual Eligible Financial Alignment Demonstration Waiver, with appropriate report-back on developing specifics of the proposal.

Specific legislative action related to the SIM grant include approval of receipt of the grant after it was awarded through the Legislature's Joint Fiscal Committee and ongoing updates on project activities requested by the Legislature's Interim Health Care Oversight Committee.

KEY INDIVIDUALS IN STATE INNOVATION MODEL PROJECT LEADERSHIP

Name	Organization	SIM Role
Anya Rader Wallack, Ph.D.	Agency of Administration/Governor's Office	Core team chair
Robin Lunge	Agency of Administration/Governor's Office	Core team member
Doug Racine	Agency of Human Services	Core team member
Mark Larson	Department of Vermont Health Access	Core team member
Al Gobeille	Green Mountain Care Board	Core team member
Lisa Ventriss	Vermont Business Roundtable	Core team member
Paul Bengston	Northeastern Vermont Regional Hospital	Core team member
Susan Wehry, Commissioner	Department of Disabilities, Aging and Independent Living	Core team member
To be hired	Agency of Administration	Project Director
Paul Dupre, Commissioner	Department of Mental Health	Steering Committee Member
Harry Chen, Commissioner	Department of Health	Steering Committee Member
Dave Yacavone, Commissioner	Department for Children and Families	Steering Committee Member
Stephanie Beck, Director of Health Care Operations, Compliance & Improvement	Agency of Human Services	Steering Committee Member

Richard Slusky	Green Mountain Care Board	Director of Payment and Delivery System Reform/SIM Project Manager
Kara Suter	Department of Vermont Health Access	Director of Payment Reform/SIM Project Manager
Georgia Maheras	Green Mountain Care Board	Project Fiscal and Grant Manager
Kate Jones	Department of Vermont Health Access	Project Fiscal and Grant Manager
Don George	CEO, Blue Cross Blue Shield of Vermont	Work Group co-chair
Stephen Rauh	Health policy consultant and member of the GMCB Advisory Committee	Work Group co-chair
Bea Grause	President, Vermont Association of Hospitals and Health Systems	Work Group co-chair
Susan Barrett	Bi-state Pirmary Care	Work Group co-chair
Simone Rushemeyer	Behavioral Health Network	Work Group co-chair (invited)
Matt Watkins, M.D.	Fletcher Allen Health Care and Northern New England Cardiovascular Disease Study Group	Work Group co-chair (invited)
Deborah Lisi-Baker	Disability Policy Expert	Work Group co-chair
Judy Peterson	Visting Nursing Association of Chittenden and Grand Isle Counties	Work Group co-chair
Catherine Fulton	Vermont Program for Quality in Health Care	Work Group co-chair
Laura Pelosi	Vermont Health Care Association (Nursing Homes)	Work Group co-chair (invited)
Harry Chen, M.D.	Commissioner of Health	Work Group co-chair

Karen Hein, M.D.	GMCB Member	Work Group co-chair

Key Artifacts:

Exhibit	Artifact	URL
144	Stakeholder Engagement Plan	
145	State Demonstration to Integrate Care for Dual Eligibles (Vermont Proposal)	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VermontProposal.pdf
69	Executive Order (DRAFT) Health Care Workforce	
88	Governor Shumlin's Health Care Press Releases	
	Legislation and Statutes	
32	Act 48	http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
35	Act 171 (Section 33: Dual Eligible Project Proposal)	http://www.leg.state.vt.us/docs/2012/Acts/ACT171.pdf
35	Act 171 (Section 34: Global Commitment; Choices for Care; SCHIP)	
9	18 V.S.A. § 701 - 741 (Chapter 13: Chronic Care Infrastructure and Preventive Measures)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=013
	Contracts and Budgets related to Governance and Management	
139	SIM Project Management RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PMO_RFP061413.pdf
140	SIM Project Management RFP Questions and Answers	http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PM_RFP_Questions.pdf
64	Contract - Bailit Health Purchasing (Payment Reform)	http://gmcboard.vermont.gov/sites/gmcboard/files/Bailit_23886.pdf

Section B Coordination with Other CMS, HHS, and Federal or Local Initiatives

This section describes coordination between SIM and CMS/HHS/federal and other CMMI initiatives.

Question 5. Has the state coordinated SIM with:

- **1115(a) Medicaid Demonstrations;**
- **Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient Centered Medical Homes;**
- **Comprehensive Primary Care initiative;**
- **Duals integration;**
- **Medicare Advanced Primary Care;**
- **Initiatives from related agencies like CDC, HRSA and AHRQ?**

Question 6. Has the state determined how it will coordinate SIM with regional and local initiatives?

Vermont has underway a number of separate initiatives aimed at improving service delivery, testing new payment methodologies and expanding health information technology. Our goal under the SIM project is to put in place an overarching framework and coordinated program of health care delivery models, payment structures and information technology that maximize system improvement and minimize duplication of effort or funding. Vermont's history of proactive involvement in federally-supported health reform on multiple fronts is a strength upon which we can build, rather than a problem to solve. The SIM grant provides a much-needed coordinating initiative to allow the design and implementation of our initiatives to proceed under an aligned model. Section A described how we would achieve that coordination, in the sense of describing a project governance and management structure that represents the people and groups affected by project activities and engaged in carrying them out, as well as leadership of related efforts outside of the grant. This section describes how we will utilize that decision-making structure to achieve coordination across separate initiatives.

Pre-existing initiatives that have been authorized by CMS include:

- Vermont's 1115 "Global Commitment" Medicaid waiver, under which the State's Agency of Human Services contracts with the Department of Vermont Health Access to function as a managed care entity on behalf of all Medicaid enrollees in the state. The state and CMS currently are negotiating a renewal of this waiver.
- Vermont's Multi-payer Advanced Primary Care Practice Demonstration (the "Blueprint for Health"), which has assisted 113 primary care practices serving approximately 483,000 Vermonters (of a total population of about 625,000) in meeting NCQA Patient Centered Medical Home standards, developed a statewide network of community health teams and practice facilitators and developed a clinical data repository to support practice management and improvement. The Blueprint for Health is the foundation of Vermont's health reform efforts and has made models planned under SIM more feasible. Given their efforts and expertise, staff of the Blueprint for Health will be involved in all Work Groups and on the Steering Committee to ensure coordination and leveraging of infrastructure and resources developed under the MAPCP.
- Creation of two approved Medicare Accountable Care Organizations that are participating in the Shared Savings ACO program (OneCare Vermont and Accountable Care Coalition of the Green Mountains), as well as participation of Dartmouth-Hitchcock in the Pioneer ACO Model
- Vermont's Choices for Care Medicaid Waiver, which provides flexibility to the state to shift long-term care spending toward home and community-based services
- The Support and Services at Home (SASH) Project, which provides health care coordination and other support services, in coordination with Blueprint practices, for high-need individuals in public housing
- The Bundled Payments for Care Improvement (BPCI) Program, under which providers from eight organizations in the Rutland area are coordinating care for congestive heart failure patients
- State and federal investments in Vermont's health information infrastructure and "Learning Health System"
- CDC-supported initiatives, including the Community Transformation grant, which uses the Support and Services at Home (SASH) infrastructure developed as part of the Blueprint for Health to support residents of housing communities with hypertension management and tobacco cessation. Several learning collaboratives described in Section M (Cancer Screening, Asthma Care, and MDRO/HAI Prevention) have been partially supported by CDC funding. CDC's support of Vermont's Behavior Risk Factor Surveillance Survey provides ongoing data on population health measures, including many of the measure recommended by CMMI for SIM evaluation.

In addition, other initiatives are under development and require federal and/or state approval. These include:

- The Financial Alignment Demonstration (the "Duals Demo"), under which the state received a grant from CMS to design a program of state-level management of Medicare funds spent on individuals who are dually eligible for Medicare and Medicaid. The state has begun negotiations with CMS regarding the details of a memorandum of understanding that would spell out the terms and conditions under which the state could continue to pursue this project.
- Medicaid Health Homes. The "Hub and Spoke" is a Medicaid Health Home specific to opiate addicted beneficiaries which launched in 2013 and is projected to be rolled out state-wide by 2014. This model was consistent with Medicaid's Integrated Care Model guidance for Health Homes and is eligible for a 90/10 FMAP match by the Center for Medicaid and CHIP Services. Medicaid expects to broaden this initiative to other beneficiaries with complex mental or physical health needs in 2015.
- Expansion of the Medicare ACO Shared Savings Program. Seven of Vermont's federally qualified health centers (FQHCs) have filed an application to be a Medicare Shared Savings ACO. That application is pending CMS approval.

The existence of such a broad range of programs illustrates Vermont's proactive stance on health care reform and the high level of interest from a variety of organizations in pursuing similar goals. Despite many of these efforts having similar goals, there is a clear potential for misalignment across these multiple initiatives, and for conflict between the rules governing the programs at the state and/or federal levels. Under the SIM project, we have the opportunity to instead create alignment and coordination across our efforts and have designed the SIM governance and management model described in section A to fill a distinct need in Vermont for an identified structure that will achieve alignment. We will use the SIM governance and management structures described above to reach agreement on two general subjects:

1. Core project components that should align and provide consistent incentives and operational models for health care providers, including:
    a. Payment models and population attribution methodologies;
    b. Quality and performance measures for both reporting and payment models;
    c. Care models designed to support individuals and populations in health improvement, disease management and service coordination;
    d. Population health improvement activities that address underlying factors affecting population health; and
    e. Infrastructure investments in health information exchange, population-based analytics and new or transformed operational processes in the public and private sectors.

2. Areas in which the federal or state rules governing the initiatives may be in conflict, and therefore state or federal policy change or flexibility may be necessary for the models to align.

Specifically, we will use the project governance structure described in section A to assure that decision-making by the SIM Steering Committee and SIM Core Team reflect awareness of potential conflict between initiatives, and reflect an effort to align policy and practice. In addition, the SIM work groups will have as a specific charge aligning their content areas with other work groups addressing the same substantive areas. Examples include:

Models of Care

Integrated Care Providers (ICPs) are the hallmark and primary innovation included in the Duals Demo design to date. The design revolves around the provision of enhanced care coordination and a single point of contact for duals with complex physical or mental health needs. It will promote integration across currently isolated LTSS and MH&SA providers into a single coordinating entity. One key area of integration of the ICP model is to ensure it is consistent with Blueprint, the models of care under development by the state's ACOs and the Medicaid Health Home development. To achieve this coordination, the Duals Demo and the Care Models and Care Management workgroups will work together to identify a systematic approach that is consistent with current evidence and assures efforts are complementary so when rolled out, the same model is applied to both dual eligible as well as Medicaid beneficiaries with highly complex physical or mental health needs. Moreover, the scope of the SIM grant has been expanded to include Medicaid Health Home expansion activities to ensure that there are sufficient resources to design and implement these initiatives concurrently. These groups also will examine the advantages and disadvantages of segmentation of the population for purposes of care models – to what extent should care models be consistent across a large (for Vermont) population versus targeted to the needs of specific sub-groups?

Payment models

Integrated Care Providers-PLUS (ICP-PLUS) is a proposed expansion of the ICP model that would incorporate a bundled payment system for specified LTSS and MH&SA services in year two or three of the demonstration—eliminating negative fee for service incentives and duplication of services while promoting coordination and efficiency. The model would also introduce accountability through the introduction of some downside risk for the delivery of long-term

services and supports and mental health and substance abuse services. The key area of integration here is between the ICP-PLUS model and the Episodes of Care (EOC) program planned under the SIM. To achieve this coordination, both the Duals Demo and Payment Model Standards Work Groups will work together to ensure that the episodes and resulting bundled payment models are consistent and when rolled out, are complementary across formerly dual eligible as well as Medicaid beneficiaries (and potentially commercial payers to the extent they have eligible populations). Likewise, shared savings programs will be designed with an explicit requirement of alignment across payers and populations, or identification of the reasons why such alignment is not possible. With multiple approaches to shared savings in play, it is imperative that we avoid double-counting of either overall savings achievements or shared savings with providers.

Attribution

Currently there are two Vermont Medicare SSPs which have dual eligibles as part of their attributed populations. Also, as part of SIM, Medicaid will launch a SSP in 2014. For year one, Medicaid will not include dual eligibles in its program. In 2015, the state will need to work with Medicaid and Medicare to ensure that those who are dually eligible are attributed to the correct ACO: either Medicaid SSP or Medicare SSP. There could be implications to this move such as existing Medicare ACOs falling under the 5,000 beneficiary threshold for participation or increasing an ACOs' Minimum Savings Rate (MSR). Also, the Medicare ACOs have significant numbers of attributed Medicare beneficiaries with disabilities who are not dually-eligible but who share common needs and would benefit from the same programs as dual eligibles. Therefore, the decision for how to account for these beneficiaries in 2015 will need to be vetted and thoughtfully discussed by all stakeholders. To achieve this coordination, the Duals Demo and Payment Model Standards Work Groups will work together to ensure that the implications of moving the dual eligibles from the Medicare to Medicaid SSP ACO models are well understood and any adjustments to programmatic standards are coordinated among the payers and ACOs. This Work Group also will assess opportunities for coordination with ACO approaches for the Medicare disabled, but not dually-eligible, population.

Also, more broadly, all the commercial and Medicaid SSP designs and standards development have included actively trying to align and mirror Medicare's Shared

Savings Program where possible. Only slight variations have been necessary given the unique patient population or commercial versus public payer arrangements (see Section P for details).

Coordination of SIM Activities with CDC and AHRQ Initiatives in Vermont

There are several CDC-supported initiatives in Vermont that coincide with the SIM Operational Plan. These initiatives fall into the areas of care transformation and quality improvement, and population health measures.

CDC grants for Community Transformation, Cancer Screening, Asthma Care, and Multi-Drug Resistant Organism/Healthcare Acquired Infection Prevention are all examples of care transformation and quality improvement initiatives that will support the payment and delivery system reforms envisioned by Vermont's SIM Plan.

The Community Transformation work uses the Support and Services at Home (SASH) infrastructure developed as part of the Blueprint for Health to focus on hypertension management and tobacco cessation. SASH provides residents of housing communities with self-monitoring tools, self-management programs, support in developing self-management plans, and access to health screening.

As described in Section M of this Operational Plan, Vermont has implemented learning collaboratives for Cancer Screening, Asthma Care, and MDRO/HAI Prevention in order to improve care and ensure the adoption of best practices. All of these efforts have been partially supported by CDC funding.

CDC's support of Vermont's Behavior Risk Factor Surveillance Survey provides ongoing data on population health measures, including many of the measures recommended by CMMI for SIM evaluation.

In terms of future activities, discussions were initiated with CDC and the National Governor's Association at a recent technical assistance day coordinated by the Governor's Office. One potential outcome from those discussions is the development of an Accountable Care Community (ACC) pilot, where healthcare, community and public health partners in one region of the state would select priorities for addressing risk factors for chronic illness (e.g., obesity, tobacco use). CDC supported data sources would provide ACC with data and technical assistance to address these risk factors. Development of this model will be coordinated, through the SIM Care Models and Care Coordination Work Group, to assure alignment across efforts.

AHRQ has also supported Vermont's payment and delivery system reform efforts. The most recent example of that is a professional production of several short documentary films and a webcast panel discussion about the Blueprint for Health that aired in September 2012, and was funded by AHRQ's Innovations Exchange. The program, entitled "Vermont Blueprint for Health: Working Together for Better Care" can be seen at: http://www.innovations.ahrq.gov/webevents/index.aspx?id=44.

Question 6. Has the State determined how it will coordinate SIM with regional and local initiatives?

As a small state, Vermont tends to have statewide initiatives with regional or local components, making coordination between these efforts easier than in most states. There is limited local government at the municipal level and virtually no county government structure in Vermont. The Vermont Department of Health and the Agency of Human Services have regional presences throughout the state in order to implement public health efforts locally and provider human services to the population in each county.

To ensure coordination with both state and local public health initiatives, a Population Health Work Group will be convened under SIM (see Section A). The forum will ensure coordination and identification of gaps in public health initiatives ongoing in the state, as well as to ensure that a population health focus is maintained throughout the project. There is similarly a "Workforce" Work Group charged with coordination activities at both a state and local level. These Work Groups will have membership that represents a diverse array of stakeholders working at various levels across the state.

The Blueprint is implemented regionally in Vermont, in each of 14 health services areas. As described previously in this Section, there is strong coordination in between SIM activities and the Blueprint for Health; Blueprint representatives will be included on SIM work groups, and many SIM activities will be based on the Blueprint's foundation of patient centered medical homes and regional community health teams.

Self-management programs, including programs for people with diabetes, chronic illness, pain, mental illness and tobacco independence, are offered through the Blueprint and other local organizations. SIM activities relevant to self-management will coordinate with this already-existing infrastructure.

The learning collaborative described in Section M (Cancer Screening, Asthma Care, and MDRO/HAI Prevention) will support the care transformation that is essential for SIM success.

Additional learning collaboratives will be supported by SIM; input from SIM work groups will be used to identify areas with quality gaps that could benefit from SIM-supported learning collaboratives.

All of Vermont's hospitals are not-for-profit organizations; they have conducted local needs assessments and offer a variety of healthcare programs in their communities. The needs assessments are already being used by regional community health teams to identify gaps in services and by the GMCB to gauge hospital investments in community health improvemnt. Hospitals will be well-represented on all SIM work groups, including the Population Health Work Group, providing opportunities for further use of the needs assessments and coordination with hospital-sponsored healthcare programs.

Question 7. Has the State fully-integrated or aligned its planned transformation with existing SPA and waiver authorities?

1115(a) Medicaid Waiver and the Choices for Care (CFC) Waiver

Vermont has submitted its application for renewal of its 1115(a) waiver and has proposed consolidating its CFC Waiver—its long term services and supports waiver—and its CHIP populations to fall all under the new 1115(a) waiver. Discussions have begun and while not a specific workgroup under the SIM grant, there is significant overlap with staff from the operations team, the Work Groups, Steering Committee and Core Group to ensure that decisions and standards made with regard to the waiver are communicated and incorporated into all SIM work related to Medicaid. See the appendix for artifacts related to Vermont's Medicaid waivers.

Question 8. Not relevant to Vermont's initiative.

Key Artifacts:

Exhibit	Artifact	URL
71	Global Commitment to Health Section 1115 Demonstration	
73	Global Commitment Waiver Evaluation Plan	
72	Global Commitment to Health Section 1115(a) Demonstration Waiver Extension Request	
164	Vermont Healthcare Associated Infection Prevention Plan	http://www.cdc.gov/HAI/pdfs/stateplans/vt.pdf

Section C Outreach and Recruitment

The section details the importance of outreach and recruitment to ensure that Vermonters will purchase insurance through Vermont Health Connect, or the Exchange. The section also discusses the state's strategy for reaching out to beneficiaries about how they can change how they are involved in their own care.

Question 9. Is the outreach and recruitment program (per its Stakeholder Engagement Plan) consistent with the features of the innovation model?

Vermont's SIM project potentially encompasses the entirety of the state's population and all Vermonters are considered "beneficiaries" by virtue of residency. The project will be implemented statewide and on an all-payer basis, to the greatest extent possible. By the conclusion of the model testing period, the state aims to have included 90 percent of the population in alternatives to fee-for-service payment models.

Vermont will test three alternative payment models: Pay-for-Performance, Episode-Based Payments, and Shared Savings models. None of these are enrolled models that change the experience of coverage from the patient perspective, nor do they restrict provider choice. If successful, the models will improve patients' experience of care in an "invisible" way – providers will have incentives to better coordinate care, shift resources toward prevention and primary care and improve service without any new restrictions on access to services or providers.

Vermont's proposed payment models will be implemented through Medicaid, commercial payers and Medicare. Therefore we will focus our outreach and recruitment efforts on enrolling Vermonters in coverage through which they can realize the benefits of their payer's participation in the SIM efforts. Vermont has designed its Health Benefit Exchange (Marketplace) to be the single point of entry into coverage for Vermonters who are eligible for Medicaid, those who are enrolling in coverage through a small employer (employees of 50 or fewer) and those who are enrolling in coverage without employer sponsorship. Vermont and Washington, DC are the only jurisdictions within which all small employers and individuals will purchase coverage through a single marketplace.

We estimate that 100,000 Vermonters will purchase commercial health insurance coverage through VHC in 2014. Another 170,000 Vermonters will access Medicaid coverage through this avenue. In 2016, employers with fewer than 100 employees will purchase coverage through VHC. With such a large proportion of Vermonters potentially obtaining health care coverage through VHC, successful beneficiary outreach and recruitment through VHC will be critical to the success of the SIM. The state's goal will be to maximize coverage through VHC and reduce Vermont's uninsured population to the greatest extent possible. The efforts planned to maximize enrollment in VHC are described below. In addition, we describe outreach, education and recruitment planned specifically for enrollees in new health care delivery models.

Outreach and Recruitment for Vermont Health Connect

The Vermont Health Connect (VHC) outreach and recruitment materials, included in the appendixand described in detail in the VHC Outreach and Education Plan, provide beneficiaries with appropriate information about the changes that they can expect regarding their health care coverage and the actions that they need to take to remain or become insured in the state of Vermont. These materials are informed by focus groups, market studies, and stakeholder inquiries. VHC has and will continue to use a robust and diverse outreach strategy to educate Vermonters about the Exchange.

Advertising

To raise awareness among all Vermonters, VHC will use 30 second television pieces, 15-30 second radio ads, newspaper print, online banners, search engine copy, and Facebook promotions. Printed materials such as brochures, table tents, payroll inserts, direct mailings, and palm cards will also be distributed widely in the state. VHC will take advantage of opportunities for outreach by developing strong partnerships with local media and creating a presence at popular local events, such as county fairs. VHC has a social media presence on Facebook, Twitter and YouTube. On YouTube the Exchange has three FAQ videos that are provided as links in the artifacts for this section.

Direct Outreach

VHC began conducting direct outreach to consumers in the fall of 2012 using public forums. Public forums have been conducted in every region of the state. Public forums have included presentations and Q and A sessions conducted by state employees, sometimes in cooperation with representatives from Chambers of Commerce or others representing small businesses. A list of press releases announcing public forums can be found in the appendix.

More than 100 presentations about VHC have been made statewide. Some of the presentations are public forums, while others are private events hosted by a local business or group, and others are a hybrid. Monthly Webinars have also been popular and well attended. A power point presentation specifically for small businesses is also available in the appendix.

VHC will create a "Train the Trainer" program to involve key stakeholders in educating their constituencies by providing them with a consistent message and package of information.

Customer Service and Support

VHC will also have a Customer Support Center (CSC) with a toll-free hotline to assist all Vermonters seeking health insurance.

In order to accommodate those Vermonters that would prefer to access VHC with the help of an individual rather than directly through the website or over the phone, the Navigator program was created. Navigators for VHC will provide direct assistance to consumers purchasing insurance through VHC. Approximately 150 Navigators are available in communities throughout the state to help Vermonters understand their health care options, enroll in a plan, and access financial help. Small employers and their employees can also turn to Navigators for help in determining their best health coverage options. Navigators are managed by 18 organizations and partnerships selected in a competitive grant application process. In May, 2013, VHC announced $2 million in funding to Navigator organizations. A list of Navigator organizations is provided in the appendix, as is a link to the page of press releases that have been issued about VHC, including the selection of Navigators.

Persons interested in serving as brokers or Certified Application Counselors will participate in the same training as Navigators. The certification program will ensure appropriate training, require compliance with privacy and confidentiality, and give Vermonters a sense of confidence with VHC.

Vermont's updated Stakeholder Engagement Plan includes regular communications with the Medicaid and Exchange Advisory Board, which advises Vermont Health Connect on outreach and recruitment activities. (See Updated Stakeholder Engagement Plan in the appendix). Additionally, the SIM Governance Structure includes membership on the Government Operations, Steering Committee, and Core Team from the Department of Vermont Health Access, which is responsible for Vermont Health Connect. These interfaces will encourage information sharing between the staff carrying out the specific work of the SIM grant and those who are involved with education and outreach for Vermont Health Connect. In this way, those involved with the SIM project can stay informed about the beneficiary outreach and recruitment activities and the stakeholders that advise on these activities can also stay informed about how they relate to the SIM grant.

Beneficiary Outreach, Education, and Recruitment for New Delivery Models

The alternative payment models that Vermont has proposed do not require beneficiary enrollment or a decision to "opt-in". However, some models that will be tested in Vermont have "opt-out" components where beneficiaries can choose not to participate. An example of an "opt-out" component is within the Medicare Shared Savings Program. In this model, beneficiaries have the choice not to have their claims data shared with the ACO that is managing their care. Although a beneficiary may opt-out of having their claims data shared with the ACO, the ACO will still be fully accountable for the beneficiary's care, costs, and outcomes. OneCare beneficiaries, who will be attributed to the ACO for the purposes of the Medicare Shared Savings program have been sent a letter describing the ACO and providing an opportunity to opt-out of having their Medicare claims data shared with the ACO.

The Medicaid ACO model that will be tested as a part of Vermont's SIM Project likely also will have an opt-out provision. The standards for this model will be developed by the SIM Payment Models Work Group. This group has been developing standards for commercial ACOs over the course of 2013. These standards will be implemented in 2014. The state is working to align all of these programs so beneficiaries will have a similar experience across all payers and so providers will have a similar set of expectations when delivering care to beneficiaries that may be individually attributed to the different ACOs.

Likewise, Vermont's dual eligibles demonstration project likely will include an opt-out provision for beneficiaries. Details of this option have been included in Vermont's plans for the project previously submitted to CMS (see appendix).

Although Vermont's proposed model testing program does not include enrolled models, some of the payment models are very directly linked with delivery system reforms that require outreach to beneficiaries to promote participation and engagement in these innovative care

models. These models require that beneficiaries are activated in their care delivery. For instance, if a model requires a beneficiary to select a care coordinator or access enhanced care coordination services, proper outreach and education must be included in the model to encourage participation. This approach to beneficiary outreach and education will build on Vermont's experience with the Blueprint for Health and the Vermont Oncology Pilot Project. These existing models provide us with evidence that this approach maximizes the patient and caregiver's roles on the health care team. These two programs have already implemented strategies for reaching out to beneficiaries about changes in the delivery of their care. These strategies include direct communications with patients about their care as well as communication materials targeted towards patient activation in care and self-management.

Future Work on Beneficiary Outreach, Education, and Recruitment

1. The Blueprint for Health has begun major work in the area of shared-decision making, and the GMCB is encouraging more providers to adopt this approach to patient care. By specifying shared-decision making as a delivery system reform model to be supported as a health reform cost in hospital budgets, the Board makes this priority clear.

2. In its application for SIM funding, Vermont specified that it would use the "How's Your Health Tool" as a way to evaluate patient engagement and activation. The "How's Your Health Tool" asks patients questions that prompt them to improve their self-care along with questions that provide insight to providers on the patient's health status and satisfaction. "How's Your Health" is a web-based tool that will require beneficiary outreach and education in order to encourage its use and maximize its value. "How's Your Health" is also being considered as a possible tool for measuring patient engagement for the purposes of monitoring commercial ACOs in year 2 or 2015. Vermont will devise and implement a beneficiary outreach strategy, specific to using the "How's Your Health" tool by June 1, 2014.

3. Vermont will develop, by 2015, a standardized process for reaching out to and educating beneficiaries, and beneficiary representatives across the stakeholder groups, about proposed delivery system reforms that will require changes in patient behavior or service delivery.

4. Vermont will continue to engage a diverse and widely representative group of beneficiaries through the activities specified in its Updated Stakeholder Engagement Plan.

Key Artifacts:

Exhibit	Artifact	URL
	Stakeholder Engagement	
144	Stakeholder Engagement Plan	
141	SIM Stakeholder Meeting Schedule	
	Vermont Health Connect Outreach Plans	
154	Vermont Health Connect Education and Outreach Plan	http://healthconnect.vermont.gov/sites/hcexchange/files/For%20Websitevermont-health-connect-outreach-and-education-plan.pdf
161	Vermont Health Connect website	http://healthconnect.vermont.gov/
162	Vermont Health Connect YouTube Channel	http://www.youtube.com/user/VTHealthConnect?feature=watch
158	Vermont Health Connect Small Business Presentation	
	Vermont Health Connect Public Engagement Research	
155	Vermont Health Connect Focus Group Findings (Name/Logo)	
156	Vermont Health Connect Focus Group Findings (Public Education)	
160	Vermont Health Connect Survey Results (awareness, access, barriers)	
159	Vermont Health Connect Stakeholder Findings	
157	Vermont Health Connect Press Releases - Public Forums	
56	**Blueprint for Health Outreach Materials**	
	Smoking Cessation	http://www.vtquitnetwork.org/
	Chronic Disease Self-Management Program	http://hcr.vermont.gov/sites/hcr/files/Microsoft%20Word%20-%20CDSMPOverview.pdf
	Chronic Pain Self-Management Program	http://hcr.vermont.gov/sites/hcr/files/Microsoft%20Word%20-%20Chronic%20Pain%20Overview.pdf
	Diabetes Self-Management Program	http://hcr.vermont.gov/sites/hcr/files/Microsoft%20Word%20-%20Diabetes%20Overview.pdf
	Calendar of Healthier Living Workshops	http://hcr.vermont.gov/sites/hcr/files/20

		13%20HLW%20for%20the%20web-02-25-2013.pdf
144	**OneCare Participant Outreach Materials**	
	OneCare/Medicare Letter to Beneficiaries	
	Beneficiary Info Sheet	
	OneCare Patient Fact Sheet	
	Consent to Change Personal Health Information Preference	
	Additional Outreach Materials	
166	Vermont Oncology Pilot Project Brochure	
79	GMCB Guide - Rate Review	http://gmcboard.vermont.gov/sites/gmcboard/files/RRGuide.pdf
78	GMCB Guide - Hospital Budget Review	http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB%20Hospital%20Budget%20Review.pdf
77	GMCB Guide - Health system reform	http://gmcboard.vermont.gov/sites/gmcboard/files/Guide_VTHealth_System_Reform.pdf
98	How's Your Health? website (home page - howsyourhealth.org)	http://www.howsyourhealth.org/

Section D Information Systems & Data Collection Setup

This section provides a description of the information systems that support the meaningful exchange of information and provide timely data collection and analysis.

Question 10. Has the state developed an underlying IT infrastructure to support the intake of data for new payment and delivery reform initiatives?

Vermont will rely on several data sources to support the SIM project, including: electronic health records, claims data, and clinical registry data.

Vermont is far along in its electronic health record process and the development of a statewide approach to sharing clinical and patient information for point of care decision making, analytics and population health management. Over the last several years Vermont Information Technology Leaders (VITL), the state's designated entity for developing and operating the statewide Vermont Health Information Exchange (VHIE), has assisted healthcare providers with: 1) adopting and implementing electronic health records (EHR); 2) developing the interfaces necessary to exchange clinical and patient information and 3) deploying the technology infrastructure to allow providers to obtain clinical data.

Currently all Federally Qualified Health Centers (FQHC) and all of Vermont's acute care facilities have EHRs. Additionally, approximately 85% of Vermont's primary care providers have EHRs and 77% of all office based physicians have EHRs. All of Vermont's acute care facilities, FQHCs and over 100 practices and other healthcare organizations are connected to the VHIE, resulting in approximately 2 million transactions per month being processed by the VHIE. In 2013 the VHIE will go-live on a provider portal which will allow any healthcare provider (with internet capability, approved roles based access and patient consent), to query and receive clinical data that was generated on their patients by other healthcare providers across Vermont. The provider portal will also include a master person index (MPI) comprised of over 800,000 persons and offer claims based medication history on Vermont patients.

VITL also supports analytics activities. Clinical data pertinent to Blueprint for Health practices is provided to a clinical registry/ structured repository (currently operated under contract by Covisint DocSite), which will provide clinical data to support improvements in health and health

care services. VITL is also working with Vermont's accountable care organizations (ACO) to provide clinical data that can be combined with claims data to perform analytics and provide reports to providers.

The Vermont Healthcare Claims Uniform Reporting & Evaluation System (VHCURES) includes a consolidated set of healthcare claims data from commercial payers and Medicaid. VHCURES has a subset of Medicare data, which will be expanded this year. Further improvements in the data set and data access are also planned. Vermont is in the process of further investing in a quality assurance program giving payers an expanded role in data validation.

Vermont has committed to continual review of its data systems to ensure we have the best data available for analysis of this project and the starting point for this is a gap analysis being performed by SHADAC as part of the CMMI technical assistance. Reflecting the commitment to improve data systems, Vermont is initiating a data governance program for its all-payer claims data to ensure that these data will properly support key business initiatives including integrating well with clinical data (see the draft governance program document). This program includes multiple-agencies to ensure cross-collaboration in the development of effective business definitions, business rules, and data policies. The VHCURES governance council will meet regularly to review and make tactical decisions regarding the management of the data system with guidance from a technical workgroup and a data research and review group. In addition, a stable group of data stewards and subject matter experts will inform the council. The document itself defines roles and responsibilities for individuals participating in the governance of VHCURES and is intended to change as the program develops.

All clinical and claims data in Vermont are confidential and private following both federal and state laws and policies. For more information regarding privacy protection see Section J.

Question 11: What are the process(es)/mechanisms for data collection to support the state's delivery system and payment reform efforts?

Vermont has developed processes and mechanisms for data collection on a regularly defined basis to support its delivery system and payment reform efforts. The data and related processes used in the SIM project is further described in the table below and evidence provided in the listed artifacts for Section D. For procedures and processes around the claims database please see the statement of work with the data warehouse vendor and VHCURES Vermont State Rules

& Carrier Working Documents. Information on the clinical data can be found in the VITL reports. Information on the Medicaid data can be found in the advanced planning documents as well as the claims database artifacts. Specific procedures and processes for collecting and reporting the population measures can be found in the Vermont Department of Health website.

Question 12: What is the formal measurement reporting mechanism across payers and providers?

The state has convened a SIM measurement work group and created a plan for the measurement reporting mechanism across payers and providers. This work group is discussed in more detail in Section A of this Operational Plan. Relevant measures have been identified and an RFP issued to hire a vendor to assist the state in developing performance measures, benchmarks, and the evaluation process for Payment Reform Pilots. The vendor must have the ability to perform the evaluation of these approved payment and delivery system pilot projects based on three payment models: bundled payments, hospital/physician budgets, and population-based global payments—in specific geographic areas. In addition to assessing performance related to process and performance measures, the evaluation must also consider measures related to patient experience, provider experience, caregiver experience, access to care, quality of care, and reduction in the growth of health care expenditures. This evaluation must also assess whether or not the models being piloted have relevance for statewide application. Vermont will work with the successful bidder to ensure we obtain data from payers and providers that is necessary for the SIM work. We expect the contract to begin on September 1st allowing us to sufficient time to develop the formal mechanisms for measurement and data reporting from those entities.

See below for Vermont's plan for data collection to support the SIM project.

Data	Key Function	Data Source	Progress to Date	Infrastructure Work plan milestones	Frequency of Data Submission	Consolidation for Analysis
Eligibility / Claims Data	Self-analysis of SIM Activities Monitoring of a Multi-Payer System	VHCURES	5 years of consolidated Medicaid and commercial data	• Update rule to include VHC information (Fall 2013) • Incorporate Medicare data (Fall 2013) • Improve data quality procedures (Fall 2014) • Improve data access to support analysis (Fall 2014)	Monthly	Quarterly
Clinical Data, including from Electronic Health Record Systems and other sources	Self-analysis of SIM Activities Monitoring of a Multi-Payer System	• Clinical and patient data from provider EHR systems through the VHIE to a clinical data repository/ registry and ACO analytics entities; • Clinical data	• About 85% of Primary Care Providers and 77% of Office Based Physicians have HER • All of Vermont's acute care facilities, FQHCs and over 100 practices and other healthcare	• Medication history and provider portal to query the VHIE by end of 2013 • State law requires statewide availability of Blueprint program and its	Real-Time	Annually

Data	Key Function	Data Source	Progress to Date	Infrastructure Work plan milestones	Frequency of Data Submission	Consolidation for Analysis
		repository can also receive data through website portal input	organizations are connected to the VHIE	IT infrastructure by October 2013 • Other community providers are also using the clinical registry; e.g., elder care (SASH), Community Health Teams, tobacco cessation; potential plans to expand further to mental health, long-term care, Duals, etc.		
Patient Survey Information	Self-analysis of SIM Activities Monitoring of a Multi-Payer System	Currently there are multiple sources of patient survey information	A workgroup has been convened to organize a consolidation of the survey data		Annually	Annually

Data	Key Function	Data Source	Progress to Date	Infrastructure Work plan milestones	Frequency of Data Submission	Consolidation for Analysis
VHC information • **Plan** • **Payer** • **Eligibility / Claims**	Self-analysis of SIM Activities Monitoring of a Multi-Payer System	None	Development of model to identify data required	• Update all payer claims data base rule incorporating VHC information • Enhance current database with new VHC information • As needed collect data directly from VHC payers.	Quarterly	Quarterly
Medicaid Data	Reporting Data to CMMI (TMSIS)	Medicaid Management Information System	A vendor is under contract to meet the CMS requirements for TMSIS on time (2014)	A combined advanced planning document for the funding to support the TMSIS is completed and submitted to CMS in July 2013	Monthly	Monthly
Youth Risk Behavior Survey	Population Measures for Monitoring		Vermont has identified population measures to use in support of the project		Bi-annually	Bi-annually
Behavioral	Population	Nationally	Vermont has identified		Annually	Annually

Data	Key Function	Data Source	Progress to Date	Infrastructure Work plan milestones	Frequency of Data Submission	Consolidation for Analysis
Risk Factor Surveillance System	Measures for Monitoring	standardized survey data on health related behaviors	population measures to use in support of the project			

Key Artifacts:

Exhibit	Artifact	URL
76	GMCB Data Governance Plan	
136	SIM Grant Evaluation RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/REVISED_SIM_RWJF_EvalRFP2.pdf
137	SIM Grant Evaluation RFP Q&A	http://gmcboard.vermont.gov/sites/gmcboard/files/EVALSIM_%20RFP_Q%26A.pdf
54	Blueprint 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
133	SHADAQ Data Gap Analysis Preliminary Matrix	
	Department of Health Population Health Monitoring	
193	Youth Risk Behavior Survey Web Site	http://healthvermont.gov/research/yrbs.aspx
192	Youth Risk Behavior Survey Report	http://healthvermont.gov/research/yrbs/2011/documents/2011_YRBS_statewide_report_with_cover.pdf
43	Behavioral Risk Factor Surveillance System Web Site	http://healthvermont.gov/research/brfss/brfss.aspx
42	Behavior Risk Factor Surveillance System 2011 Summary Report	http://healthvermont.gov/research/brfss/documents/summary_brfss_2011_4.13_000.pdf
	VHCURES	
170	VHCURES Data Management Contract (Onpoint - attachment A)	
171	VHCURES Data Management Contract (Truven - Statement of Work)	
172	VHCURES Data Processing (consolidation) presentation	
174	VHCURES Vermont State Rules & Carrier Data Requirements	http://onpointcdm.org/cms/images/vt-dcrr/vt_carrier_mnl.pdf
	Health IT	
169	Vermont State Medicaid HIT Plan	http://hcr.vermont.gov/sites/hcr/files/VT%20SMHP%20V1.3%20FINAL%20110903.pdf
165	Vermont HIT Plan 2010	http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-

		10__0.pdf
179	VITL - Policy on Patient Consent for Provider Access to VHIE	http://www.vitl.net/sites/default/files/documents/HIE/Vermont%20Policy%20on%20Patient%20Consent.pdf
175	VITL 2012 Annual Report	http://www.vitl.net/sites/default/files/documents/general/2012%20VITL%20Annual%20Report%20Final.pdf
176	VITL July 1, 2013 Update	

Section E Alignment with State HIT Plans and Existing HIT Infrastructure

This section provides a description of Vermont's plan to align SIM Health Information Technology (HIT) initiatives with the existing HIT infrastructure.

Question 13. Are investments that have been made by Federal programs and State governments recognized and leveraged by SIM initiatives in a coordinated and economic fashion?

Vermont has a health Information technology (HIT) program that aligns with and leverages prior federal investments in the health information exchange (HIE), meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT. Vermont statute (refer to artifact list) establishes the requirement for a comprehensive statewide health information technology plan, which outlines the strategic vision for Vermont health IT and the operational plan for making that vision a reality. The development and updating of the VT HIT Plan is the responsibility of the Secretary of Administration, who has delegated this authority to the Division of Health Care Reform in the Department of Vermont Health Access (DVHA). The VT HIT Plan is reviewed annually and any updates are approved by the Green Mountain Care Board (GMCB). The GMCB's review ensures the VT HIT Plan is consistent with overall health reform efforts and especially payment and delivery system reforms.

Under Vermont law, the Vermont Information Technology Leaders, Inc. (VITL) is designated to operate the exclusive statewide health information exchange network for the State. According to its Annual Report, VITL's progress during 2012 was in four major areas: (1) helping health care providers adopt and implement electronic health records systems (EHRs); (2) launching a Direct messaging product; (3) building interfaces enabling independent information systems to send and receive data over the health information network; and (4) deploying the network's core infrastructure, which stores data transmitted by interfaces and enables authorized users to search for and retrieve data. In Vermont, all four of these components are in place but not all are fully operational. More progress has been made on fully developing some components than others.

To ensure sustainability of HIT, in 2008 the Vermont legislature established a Health-IT Fund in the state treasury to be used for health care information technology programs and initiatives such as those outlined in the Vermont health information technology plan, including:

1. A program to provide electronic health information systems and practice management systems for primary care practitioners in Vermont;
2. Financial support for Vermont Information Technology Leaders to build and operate the health information exchange network;
3. Implementation of the Vermont Blueprint for Health information technology initiatives and the advanced medical home project; and
4. Consulting services for installation, integration, and clinical process re-engineering relating to the utilization of healthcare information technology such as electronic medical records.

Vermont has strong alignment of HIT and HIE across the State, and across initiatives that have HIT or HIE components. That alignment includes careful attention to leveraging previous and current federal investments in Vermont's expansion efforts:

1. Alignment can be traced to the history of legislative direction of healthcare reform in Vermont:
    a. 2004: HIT Summit convened by state hospital association
    b. 2005: Vermont Information technology Leaders (VITL) formed and charged by legislation to develop a Vermont HIT Plan;
    c. 2006: Landmark health reform legislation for Health Care Affordability and Safe Staffing and Quality Patient Care;
    d. 2007: First State HIT Plan published; Ensuring Success in Health Care Reform;
    e. 2008: An Act relating to Managed Care Organizations and the Blueprint for Health;
    f. 2009: HITECH; HIT-HIE oversight moved to Department of Vermont Health Access (DVHA); VITL is exclusive HIE for Vermont; VITL receives funds for HIE from the ONC under the Statewide Cooperative Agreement Program; VITL becomes the federally designated Regional Extension Center; the HIT Fund is established and the related Reinvestment Fee of 0.199 percent of claims paid;
    g. 2010: Blueprint for Health pilots codified to define medical homes, community health teams, and payment reform in statute;

h. 2011: Health Reform Legislation Implementing the Affordable Care Act and a unified, universal health program
    i. Establishes the Green Mountain Care Board, charged with changing the way we pay for health care and controlling growth in health care costs
    ii. Establishes Green Mountain Care as a universal coverage program to be implemented in 2017
    iii. Establishes Vermont Health Connect, the state-based insurance marketplace under the Affordable Care Act
i. 2012: Health Reform Implementation of the Affordable Care Act

2. Vermont's health reform efforts pre-date HITECH and Vermont was committed to and had the structure and the funding established for a health information exchange;
3. Vermont's Blueprint for Health is an early implementation of a patient centered medical home concept, and is supported by founding legislation and subsequently supported by legislation for expansion. It is the goal of the Blueprint for Health program to have every Vermont person participating in a Blueprint practice. Payment reform has also been implemented as part of the Blueprint for Health program, adding elements of an accountable care organization;
4. The Blueprint for Health program established a clinical data repository in support of evidence-based practice and a learning health system. Measure sets are established and clinical data is collected for a number of chronic conditions and acute conditions are now being addressed as well. Essentially the Blueprint for Health program represents an early adoption of Meaningful Use of HIT;
5. The Blueprint is also staffed to provide facilitation and project management assistance to practices as they implement their EHR systems and begin to move data through the exchange and into the repository. Hundreds of thousands of such transactions occur each month and there is much expansion to go. Essentially the Blueprint represents an early implementation of REC-like services;
6. Vermont is actively engaged in activities intended to expand the participants in HIE beyond the initial population of hospitals, medical providers, laboratories and pharmacies. We are funding analyses of technical exchange gaps that exist for a variety of providers not eligible for EHR incentive payments, including mental health agencies, home health agencies, and long-term care providers such as nursing homes and residential care facilities. And we are engaging these providers in use case discussions to effect improvement in transitions of care and improved workflows across the provider spectrum;
7. As identified in the State HIT Plan, there are HIT and HIE components in several initiatives in the healthcare reform landscape in Vermont, including Vermont Health Connect (VHC), Medicaid Management Information System (MMIS), Integrated

Eligibility (IE), and the Health Services Enterprise Platform (a stack of core functions and modular Service-Oriented-Architecture based components to support all initiatives mentioned here). These four initiatives along with a fifth initiative comprising all things more specifically HIT and HIE make up the State's Health Services Enterprise, managed as a portfolio through a rigorous Project Management Office (PMO) governance structure.

The associated alignment and leveraging of State and federal funding that supports the above history of HIE and HIT in Vermont healthcare reform is as follows:

1. The State HIT Fund was established to create the financial resource to support the expansion of EHR technology in provider organizations, the expansion of the HIE, and the expansion of the Blueprint program, with consulting and facilitation support of provider organizations;
2. The HIT Fund is also utilized to leverage State resources by serving as the State's matching requirement for federal funding, where the utilization is appropriate to the overall purpose of the Fund;
3. The introduction of the HITECH Act made additional funding available for HIE expansion through a Cooperative Agreement Grant, awarded to DVHA and used to fund the HIE through annual Grant Agreements, with VITL becoming a sub-grantee. The State HIT Fund provided the State's match for this grant from the Office of the National Coordinator;
4. Again through the HITECH Act, but administered by CMS, states had the option to establish incentive payment programs for EHR adoption and meaningful use by eligible hospitals and providers. Vermont first got a planning grant to develop such a program through the State Medicaid HIT Plan, and then an implementation grant to implement the program. Again, the State HIT Fund provided the State's match for these grants and the incentive program is strongly aligned with the expansion of EHR expansion with the HIE and the Blueprint for Health;
5. Separately, VITL successfully pursued a grant to become the State's only Regional Exchange Center (REC) to provide services in support of providers adopting technology and preparing for the first stage of meaningful use. This work is also aligned with the goals of the HIE and Blueprint programs and the State provided the match for VITL's grant, using the State HIT Fund;
6. The State recognized the need to adopt an architecture that would be consistent with the Medicaid Information Technology Architecture (MITA), a federal requirement for future MMIS upgrade or replacement projects. The State also saw a need for a common

core component architecture that could serve as a platform for not only MMIS but also Integrated Eligibility and other healthcare reform initiatives. A grant was awarded by CMS to support an initial implementation of this core component stack of modular tools.

7. The introduction of the Affordable Care Act brought new requirements and opportunities for pursuit of the State's long term goals in healthcare reform. The State sees implementation of the Vermont Health Connect as an opportunity to provide more immediate coverage solutions to Vermonters while leveraging federal investment and moving in the strategic directions of our health reform goals. The first phase of an Integrated Eligibility solution is required for the VHC, which will be expanded to other Vermont programs.
8. To coordinate the complex array of program initiatives underway while managing the variety of funding formulae allowed for Federal Financial Participation in each category, the State issued the first-in-the-nation consolidated (Jumbo) Implementation Advance Planning Document (IAPD), or funding request. This request lays out a grid of projects and associated funding allocations that has been negotiated with and approved by CMS. An update for the next funding period is in process. This Jumbo IAPD process is the culmination of the various elements demonstrating the alignment and leveraging of federal funding to date, and it is consistent with the State's evolved To-Be Architecture.

Vermont's SIM Proposal is a logical expansion of the HIT and HIE progress that has been made so far in the state. The SIM Proposal expands the HIE to bring more providers into the exchange and to close the gaps that have been identified with what can be considered full continuum providers – mental health, substance abuse, long-term care, and home health. The proposal also supports and expands healthcare coordination, an initiative already underway through the Blueprint program. Further, the SIM Grant will expand and advance the capture and utilization of data in support of both improved healthcare delivery and the payment reform models that are being implemented through the SIM Grant.

Key Artifacts:

Exhibit	Artifact	URL
	Reports	
175	VITL Annual Report	http://www.vitl.net/sites/default/files/documents/general/VITL%20Annual%20Report%20to%20Legislature%20Jan%202012.pdf
176	VITL July 1, 2013 Update	
	Plans	
169	Vermont State Medicaid HIT Plan	http://hcr.vermont.gov/sites/hcr/files/VT%20SMHP%20V1.3%20FINAL%20110903.pdf
165	Vermont HIT Plan 2010	http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf
54	Blueprint Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint%20Annual%20Report%20Final%2001%2026%2012%20_Final_.pdf
163	Vermont Health Enterprise - Implementation Advance Planning Document (IAPD)	http://bgs.vermont.gov/sites/bgs/files/pdfs/purchasing/VT_Health_Enteprise_APD_v4.0.pdf
	Statutes	
5	8 V.S.A. § 4089k. Health care information technology reinvestment fee	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04089k
13	18 V.S.A. § 9351. Health information technology plan	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=219&Section=09351

SECTION F IS NO LONGER REQUIRED BY CMS

Section G	Model Intervention, Implementation and Delivery

This section describes how the State can or will use policy and regulatory levers to achieve project aims and how the State will engage providers and payers in implementation of proposed testing models.

Question 15. Has the state conducted thorough analysis to identify and assess the state policy and regulatory levers available to accelerate the implementation of the proposed innovation model?

Question 16. Has the State incorporated a broad array of policy and regulatory levers (see Appendix B for examples) that are consistent across multiple areas of state influence into its proposed innovation model?

Question 17. Are current policy positions and planned actions aligned with or reflective of federal positions and stated direction?

Policy and Regulatory Levers

Vermont can bring to bear a number of policy and regulatory levers to implement the proposed innovation model and translate project learning into effective state policy after the life of the project. The innovation model we have proposed has three main foci:

- Care models
- Payment models
- Health information technology

In each area of focus, the state has some authority to set policy. However, as noted in section A, we are placing a major emphasis under this project on including others, outside of government, in further development of that policy. That approach has already been in evidence as the state has developed the Blueprint for Health and as the Green Mountain Care Board has implemented its responsibilities under Act 48.

The major policy and regulatory levers at the state's disposal include:

- Requirements for participation in the Blueprint for Health
- Medicaid contracting requirements
- Requirements of commercial health insurance carriers
- Active solicitation for insurance products offered through Vermont Health Connect through a competitive bid process
- Health insurer rate review
- Requirements for payment reform pilot projects authorized by the GMCB
- Requirements imposed through the hospital budgeting process. The GMCB sets the rate of increase in hospital net patient revenues annually, and also reviews hospital investments in innovation.
- Requirements for certificates of need for major health care capital expenditures
- GMCB authority to establish all-payer rates
- Requirements articulated in the state's Health Information Technology plan
- Management of the state's HIT fund
- Requirements articulated in the state's health care workforce plan
- Provider licensing requirements administered through the Secretary of State's Office
- Department of Health support for public health activities
- Specifications for the management contracts for the State Employees' health insurance program

Through this project, we can bring these levers to bear to encourage and accelerate project activities, and to align state policy across agencies. We also can use the project as a forum for developing consensus among stakeholders, policy makers and regulators about how the policy and regulatory levers should best be used in the future to support a sustained high performance health system. Currently, the executive branch utilizes a Health Care Leadership Team, which meets every other week, and a Health Care Cabinet, which meets quarterly, to coordinate policy across agencies and departments. There are numerous examples of departments coordinating across their jurisdictions, including:

- The Department of Financial Regulation (DFR) used its authority to convince one non-participating commercial insurer to begin participating in GMCB payment reform pilots.
- The Governor has recommended, and the legislature has approved, that the state's budgeting process for Medicaid, as spelled out in state statute, include an inflation factor for health care cost increases that is consistent with GMCB predictions of health care cost growth. In the past, no such requirement was placed on state government and costs were shifted systematically to private payers. The Governor's budget also includes funding for a rate increase in FY 14, consistent with this policy.

- DFR, DVHA, the GMCB and other relevant agencies have begun a full-scale review of the state's regulations of managed care entities, hospitals, insurers and providers with regard to health care quality. Our goal is to simplify and align quality measurement
- The GMCB, DFR, DVHA and other departments have collaborated to operationalize regular data feeds to the state's all-payer claims dataset and have worked cooperatively on data analysis, evaluation and forecasting models, particularly across the Blueprint for Health and the GMCB.

All of the above-described policy and regulatory activity is well-grounded in legislative authority. Act 48 of 2011 established a broad legislative mandate to pursue health delivery system transformation in Vermont through a variety of policy levers. This built on previous legislative action to establish and diffuse the Blueprint for Health, Vermont's Advanced Primary Care Medical Home Model. Act 48 expanded the scope of payment reform efforts, but also established the Green Mountain Care Board and gave it the explicit responsibility for using policy levers to affect the policy goals of improved patient experience of care, improved population health and reduced per capita costs. Act 48 also established the position of Director of Health Care Reform in the Agency of Administration to oversee health reform efforts within the Executive Branch and act as a liaison between the Governor's Office and the GMCB. The Director also acts as the Governor's health policy advisor to ensure that health reform activities are closely monitored by the Governor.

Act 171 of 2012 further articulated the legislative intent to support health care system change. The law transferred additional regulatory functions to the GMCB, and made clear the state's approach to regulating the individual and small group market, including providing for Vermont's individual and small-group markets purchasing exclusively through Vermont Health Connect beginning in 2014.

The legislature took additional action during the 2013 session through Act 79 to streamline the health insurer rate review process and to more closely link the state's all-payer claims dataset with regulatory and policy levers (by transferring responsibility for management of the dataset to the GMCB). Act 79 of the Acts of 2013 also improved the data collected by the Secretary of State, the Office of Professional Regulation, the Board of Medical Practice, and other bodies regulating scope of practice to improve Vermont's ability to plan for existing and new types of health care professionals needed in our workforce.

In addition, the entire executive branch is guided by the Health Reform Strategic Plan promulgated in 2012.

Incorporation of Policy Levers in SIM Initiative

We are incorporating within the SIM Governance Structure the leaders of all major departments possessing policy-making and regulatory powers related to health care system change. In doing so, we aim to assure that the SIM initiative is well-understood by the entire executive branch health-related leadership, and the results of policy development, consensus building, problem identification and conflict resolution can be effectively incorporated in the policy and practices of state departments.

Alignment of Policy Positions and Planned Action with Federal Positions

Vermont's current policy positions and planned actions are well-aligned with federal positions related payment and delivery system reform, particularly those of the Centers for Medicare and Medicaid Innovation. Vermont's Medicaid waiver, the Blueprint for Health, our development of an all-payer claims dataset, our development of a health information exchange and, more recently, passage of Act 48 all are examples of how the state has been committed, for decades, to positive health system change consistent with the best thinking at the federal level and the innovative approaches promoted by CMS. The multitude of federally-supported innovation initiatives described in section B demonstrate our intent to pursue innovation in health care payment and delivery on numerous fronts. Act 48 and the state's health reform strategic plan make clear that these activities are part of a larger state strategy aimed at coordinated, statewide, public/private health system innovation.

Question 18. Has the state identified and engaged payers and providers with formal mechanisms (e.g. implementation workgroups, stakeholder meetings, public comment processes) for communication, input, and shared decision making?

Question 19. Has the state implemented an engagement plan with mechanisms that engage a wide range of governmental stakeholders?

Question 20. Has the state implemented an engagement plan with mechanisms that engage a wide range of community/patient stakeholders?

Vermont has identified and engaged payers and providers with formal mechanisms for communication, input, and shared decision making. Vermont's governance structure, described in section A of this Operational Plan, shows the state's commitment to formal shared decision-making. Sections C and H of the Operational Plan describe stakeholder involvement in more detail.

Vermont has implemented a matrixed staffing approach to maximize efficiency in the SIM Project. Staff from the Green Mountain Care Board, Department of Health, Department of Vermont Health Access, Department of Disabilities, Aging and Independent Living, Department of Mental Health and the Agency of Administration will work on SIM-related activities. They are represented on SIM committees and workgroups in the Project's governance. The matrixed staffing structure is described in more detail in Section K of this Operational Plan.

Vermont has implemented an engagement plan with mechanisms that engage a wide range of community/patient stakeholders. Vermont's engagement plan is described in detail in Sections C and H of this Operational Plan and in the Stakeholder Engagement Plan submitted to CMMI in May, 2013.

Question 21: Has the state initiated implementation activities around public health integration?

As described in section A, the state will form a SIM Work Group to address population health and public health integration. The group will be charged, specifically, with:

- Examining current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:
    - Enhancement of State initiatives administered through the Department of Health
    - Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts

- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

Additionally, the group may provide recommendations to the Commissioner of Health and the Green Mountain Care Board on how to expand the state's current health care expenditure analysis (under the purview of the GMCB) to include categories of spending not currently included, that may have a demonstrated impact on population health, and how to align dashboard indicators and outcome measures between GMCB and VDH.

Key Artifacts:

Exhibit	Artifact	URL
119	Payment Reform Models Overview (Status of Payment Models)	
110	National Governors' Association Technical Assistance Meeting Materials	
69	Executive Order (DRAFT) Health Care Workforce	
81	GMCB Hospital Budget Guidance FY14-16	http://gmcboard.vermont.gov/sites/gmcboard/files/Hospital_Budget_Guidance_FY14-16.pdf
	Contracts proposed or in force	
64	Contract - Bailit Health Purchasing (Payment Reform)	http://gmcboard.vermont.gov/sites/gmcboard/files/Bailit_23886.pdf
65	Contract - Burns and Associates	
	Secretary of State OPR statutes/rules	
112	Office of Professional Regulation Administrative Rules	http://www.vtprofessionals.org/opr1/opr/admnrule.pdf
1	3 V.S.A. § 121-131 (Office of Professional Regulation)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=03&Chapter=005
	IRS requirements for community needs assessments	
82	GMCB Hospital Budget Policy - Community Needs Assessments	http://gmcboard.vermont.gov/sites/gmcboard/files/HBP_ComHNAssesmt.pdf
100	IRS Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals	http://www.irs.gov/pub/irs-drop/n-11-52.pdf
99	IRS Form 990 Schedule H Instructions	http://www.irs.gov/pub/irs-pdf/i990sh.pdf
101	IRS Notice of Proposed Rulemaking - Community Health Assessments for Charitable Hospitals	
	Statutes	
15	18 V.S.A. § 9371 - 9392 (Chapter 221: Green Mountain Care Board)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=220
9	18 V.S.A. § 701 - 741 (Chapter 13: Chronic Care Infrastructure and Preventive Measures)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=013
24	33 V.S.A. § 401, 402 (Chapter 4: Department of Vermont Health Access)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=33&Chapter=00

		4
2	3 VSA 2222a – Health care system reform; improving quality and affordability	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=03&Chapter=045&Section=02222a
	18 V.S.A. § 722. Pilot projects	Contained in 18 V.S.A. § 701 - 741 (Chapter 13)
16	18 V.S.A. § 9377. Payment reform; pilots	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09377
	18 V.S.A. § 706. Health insurer participation	Contained in 18 V.S.A. § 701 - 741 (Chapter 13)
7	18 V.S.A. § 1 - 11 (Chapter 1: Department of Health; General Provisions	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=001
	Press Releases	
86	GMCB Press Release - Vermont Oncology Pilot	
85	GMCB Press Release - RWJF Support for Payment Reform	
88	Governor Shumlin's Health Care Press Releases	
134	**SIM Application Letters of Support from payers and providers**	
	Behavioral Health Network of Vermont	
	Bi-State Primary Care Association	
	BlueCross BlueShield of Vermont	
	Brendan N. Buckley, MD	
	Dartmouth-Hitchcock Medical Center	
	Fletcher Allen Health Care	
	Healthfirst, Inc	
	MVP Health Care	
	Northeastern Vermont Regional Hospital	
	The Gathering Place	
	Vermont Assembly of Home Health and Hospice Agencies	
	Vermont Association of Area Agencies on Aging	
	Vermont Association of Hospitals and Health Systems	
	Vermont Council of Developmental and Mental Health Services, Inc.	
	Vermont Federation of Nurses and Health Professionals	
	Vermont Medical Society	

Section H Participant Retention Process

This section describes how participants are legally bound to participate in health reform, but also how the state and its partners have and will continue to foster voluntary participation and ownership of health care reform.

Question 22. How are participating payers required to implement key features of the proposed model? Also, how are they committed to participating for the duration of the model testing period?

Vermont recognizes that participant retention is essential to the success of its health reform efforts and has taken bold steps to partner with participants to establish public/private governance structures and accountability for improving the health care system in Vermont. Vermont encourages payer participation in health care and payment reform in two key ways:

- Payer participation in payment reforms is required by statute.
- Payer participation in health care reforms is promoted through inclusive public/private governance and implementation structures.

Payer Participation Required in Statute

In the State of Vermont all insurance plans and Medicaid are required by statute to participate in payment reforms that:

a. Support the Blueprint for Health
b. Are approved by the Green Mountain Care Board as payment reform pilots

Required Participation in the Blueprint for Health

Statute 8 V.S.A. § 4088h requires insurance plans in Vermont to participate in the Blueprint for Health as a condition of doing business in the state. [1]

[1] http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04088h

Statute 18 V.S.A. § 706 specifies that the Blueprint payment reform methodologies include per-person-per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating community health teams. The Director of the Blueprint, consistent with the recommendation of the Blueprint Expansion, Design and Evaluation Committee, may change the payment amounts or the payment reform methodologies. If an insurer refuses to participate, the Commissioner of the Department of Financial Regulation has the authority to levy financial penalties and to suspend or revoke an insurer's license.

Required Participation in Payment Reform Pilots

Payment reform pilots are intended to test alternatives to fee-for-service payment and are to be developed by the GMCB in cooperation with health care professionals, health care facilities, and insurers. Act 48 of 2011 and Act 171 of 2012 lay out terms for insurer participation in payment reform pilots and hold insurance plans in Vermont to the same standards of participation in payment reform pilots as for the Blueprint for Health.

Statue 18 V.S.A. § 9377 states that,

> The board shall be responsible for payment and delivery system reform, including the pilot projects established in this section.
>
> (2) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:
>
> (a) Payment reform pilot projects should align with the Blueprint for Health strategic plan and the statewide health information technology plan;
>
> (b) Health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;
>
> (c) Health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which

may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(d) The scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(e) Health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(3) In addition to the objectives identified in subdivision (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

(a) Alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(b) With input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(c) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.[2]

Payer Participation Encouraged Through Inclusive Public/Private Governance and Work Group Structures

[2] http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09377

In addition to the statutory requirement that payers participate in payment reform initiatives in the State of Vermont, payers are and have been included as partners with the state and other stakeholders in carrying out the work of health reform and in implementing the models specified in the SIM. Payers are active participants in a number of existing work groups and have been included as members in workgroups which will be formed as advisory bodies for specific initiatives supported by the SIM grant. The following are examples of how the state has already fostered payer participation in health care and payment reform activities and how the state will continue to encourage participation throughout the length of the SIM grant:

Joint Insurer Group

The Joint Insurers Group is convened by the GMCB and the Department of Vermont Health Access, and consists of representatives from the state's largest commercial insurers, Medicaid, the GMCB, and more recently, the OneCare ACO. The group meets approximately biweekly, and works through technical issues related to payment and delivery system reform pilot projects, including attribution, eligibility specifications, calculations of shared savings, and other project parameters. The group's work is presented to the Standards and Performance Measures Work Groups as recommendations; those two Work Groups determine whether the recommendations will be included in proposals to the GMCB.

Payment Models Workgroup

The Green Mountain Care Board in conjunction with the Department of Vermont Health Access formed a work group to focus on the development of regulatory standards to govern the operation of Accountable Care Organizations (ACOs) in the state of Vermont. The intent of the work group was to expand ACO programs beyond the Medicare Shared Savings Program into the Commercial and Medicaid markets in Vermont. The work group is charged with aligning standards across payers, wherever possible. Participants in this group include commercial payers and Medicaid, providers, FQHCs, consumer advocates, home health and hospice, and participants representing Health Information Exchange and health care quality activities. This group is expanding under SIM to encompass all payment models.

Quality and Performance Measures Workgroup

The Green Mountain Care Board in conjunction with the Department of Vermont Health Access formed a work group that focuses on the development of quality and performance measures to reflect the performance of ACOs relative to state objectives for ACOs operating in the commercial and Medicaid markets. This work group is tasked with identifying quality and performance measures to be used for monitoring, reporting, and payment purposes. Participants in this group include commercial payers and Medicaid, providers, FQHCs, consumer advocates, home health and hospice, Department of Mental Health, Department of Disabilities, Aging, and Independent Living, and participants representing Health Information Exchange and health care quality activities. Like the Payment Model Standards Workgroup, this workgroup is expanding its tasks under the SIM Project to move beyond ACOs to other payment models.

Vermont Oncology Pilot Project Steering Committee

The aim of the Vermont Oncology Pilot is to improve care for patients residing in the St. Johnsbury area who have been diagnosed with cancer. Specifically, the project proposes to improve patient experience and satisfaction, reduce unnecessary utilization of services and reduce overall expenditures related to cancer care. In this project, the primary care, oncology, and palliative care providers share responsibility for assessing physical and psychosocial symptoms, establishing goals of care, and assisting with decision making. Medicaid and all payers doing business in the State of Vermont participate in this this pilot project. In particular, Blue Cross and Blue Shield of Vermont has an active role in the Vermont Oncology Pilot Project Steering Committee.

SIM Project Steering Committee and Work Groups

Commercial insurers and Medicaid representatives are members of the SIM Steering Committee. The SIM Steering Committee serves as an advisory body to the SIM Core team. Members of the Steering Committee are also actively involved as co-chairs of the SIM work groups. This model of stakeholder engagement is intended to foster a strong public/private partnership and governance structure. Members of the Steering Committee have specified that they want to be accountable and directly involved in the work detailed in the SIM Operational Plan; as work group chairs, Steering Committee Members will be accountable for

operationalizing the SIM work plan. Participation by Steering Committee members in the SIM work groups will provide a direct feed of information to those Steering Committee Members that are not participating, thereby keeping the entire Steering Committee informed and up-to-date on implementation activities.

Question 23. How are participating providers required to implement key features of the proposed model?

In contrast to the payers in Vermont, health care providers are not required by statute to participate in the Blueprint for Health or the payment reforms that are and will be tested as a part of the SIM Grant. Nevertheless, there are strong incentives for providers to both participate in and drive health care reform initiatives in Vermont. These incentives include:

- GMCB regulatory authority to contain costs.
- GMCB's payment reform pilot program and technical assistance offerings to support innovation in health care payment and delivery.
- The Blueprint for Health's enhanced payments to providers and technical assistance to support providers in Health Care Reform.
- Provider participation through inclusive Public/Private Governance and Work Group structure.
- Future work to encourage provider participation in payment model testing.

GMCB regulatory authority to contain costs

The Green Mountain Care Board (GMCB) has a variety of regulatory powers to contain health care cost growth in Vermont, some of which could meaningfully change how providers are paid. The Board has not executed its authority in every aspect, instead preferring to work with providers in a collaborative fashion to stimulate innovation. Providers in Vermont have already demonstrated that they are both cooperative and engaged in the implementation of the alternative payment models specified for testing in the SIM grant. The alternative to involvement in health reform activities is an unsustainable health care cost curve that weakens Vermont's health care infrastructure. The Board has played and will continue to play a key role in fostering provider involvement in payment and delivery system reforms.

The following are GMCB regulatory powers that can be exerted to affect provider payment:

a. Act 48 of 2011 specifies that, "In its discretion, the board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals." Act 48 articulates that it is the responsibility of the Green Mountain Care Board to ensure that providers in Vermont are paid in a way that is efficient, economical, and that provides for high quality care.

b. Act 48 of 2011 specifies that it is the duty of the GMCB to review Hospital Budgets. In its guidance for the 2014-2016 Hospital Budget Review Process, the Board set a target for increases in hospital net patient revenue of three percent for the budget years of FY-14, FY-15 and FY-16. The three percent growth target is inclusive of any provider tax increases and any costs associated with unbudgeted capital investments for which the Board approves a certificate of need. The Board agreed to create an allowance for credible health reform proposals in the amount of one percent (above the base target of three percent) for FY-14, 0.8 percent for FY-15, and 0.6 percent for FY-16. Hospitals will need to convince the board that expenditures listed as health reform are truly investments in a reformed delivery system. The following are areas that the board may deem "credible":

i. Collaborations to create a "system of care"
ii. Investments in shifting expenditures away from acute care
iii. Investments in population health improvement
iv. Participation in approved payment reform pilots
v. Enhanced primary care and Blueprint initiatives
vi. Shared decision making and "Choosing Wisely" programs

While the Board's hospital budget guidance does not require that providers participate in payment and delivery system reforms, it clearly encourages providers to do so through the budget allowance for such activities.

GMCB's payment reform pilot program and technical assistance offerings to support innovation in health care payment and delivery

Act 48 of 2011 specifies that payment reform pilots approved by the Green Mountain Care Board will enjoy state supervision to ensure compliance with state and federal antitrust laws.

Moreover, providers that participate in payment reform pilots that are approved by the Board will benefit from the statutory requirement (described in the answer to question 22) that all insurers doing business in the state of Vermont participate in payment reform pilots approved by the Board. The Board's authority to supervise payment reform pilots, specifically those that test the models proposed in the SIM project give health care providers a strong incentive through a structured framework, to participate in testing alternative payment models. Already, the Board has approved and is supervising two payment reform pilot projects that have been proposed by providers and is in the process of reviewing two more pilot project applications.

Current participation in payment reform is evidence that there are strong incentives for providers to participate, and that providers can be further engaged in the expansion of model testing activities supported by the SIM grant. It should also be noted that one of the approved payment reform pilots is a shared savings model that includes every hospital in Vermont and Dartmouth Hitchcock Medical Center in New Hampshire. It should also be noted that a very high percentage of provider practices in the State of Vermont are hospital owned, demonstrating the participation of the large majority of Vermont's health care providers in the testing of the shared savings payment model.

Pilots that are approved by the Board have and will continue to receive technical assistance appropriate to the payment model and project (Payment Reform Pilot Applications). Pilots are required to be aligned with the Blueprint for Health Advanced Primary Care Practice Model, and technical assistance to achieve this alignment is available.

The Blueprint for Health's enhanced payments to providers and technical assistance to support providers in Health Care Reform

Providers participating in payment reform pilots and the Blueprint for Health receive technical assistance and funding support for practice transformation and the adoption of HIT/HIE. Providers are paid on a scale ranging from $1.36 to $2.39 (for 2011 recognition) per member per month (PMPM) depending on their NCQA PPC® PCMH™ score. Participating providers also benefit from Community Health Teams (CHTs) which receive $350,000 annually to support a general patient population of 20,000, which covers approximately five full-time positions in multiple disciplines within the core CHT. CHTs are attractive to providers because they help to coordinate care, services, referrals, transitions, and social services as well as provide self-management support and counseling to individuals with chronic illness. In 2012, providers, including CHT members, also received support and training in shared decision making and are

being provided with access to decision aids to support implementation of shared decision making.

The Vermont Blueprint has invested significantly in practice transformation assistance, funding EQuIP to provide practice facilitation. EQuIP staff teach the primary care practices change theory; assist with practice team development, NCQA application preparation, and rapid Vermont has participated in and helped to shape a national model supporting the transformation of primary care through the evolved implementation of Practice Facilitation. In *Developing and Running a Primary care Practice Facilitation Program*, published by the Agency for Healthcare Research and Quality (AHRQ) in 2011, practice facilitation is defined as:

> *…a supportive service provided to a primary care practice by trained individuals or teams of individuals. These individuals use a range of organizational development, project management, practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals.*

Vermont's Expansion and Quality Improvement Program (EQuIP) consists of a team of Practice Facilitators that assists primary care internal medicine, family medicine, pediatric and naturopathic practices with continuous Quality Improvement (QI) efforts. In 2012, 13 practice facilitators have assisted approximately 90 practices in becoming recognized by the National Committee for Quality Assurance as patient centered medical homes. The EQuIP team members come from such disciplines as social work, nursing and patient advocacy, and are all highly skilled in change management and process improvement. Facilitators are trained to develop relationships and work on-site in practices with the providers they support, working with consistent practice-based teams as much as possible.

Work with the practice facilitators continues after NCQA PCMH recognition. Practices identify their improvement goals, often informed by the NCQA scoring process and/or implementation and integration of the local Community Health Team operations. Options for practices include individual projects with their facilitator and participation in learning collaboratives as described in Section 5.c. of this document.

Provider participation encouraged through inclusive Public/Private Governance and Work Group structures

As described in #2 of the response to question #22, providers are represented in both the existing Vermont health reform governance and work group structures as well as the SIM governance and work group structures that are evolving out of Vermont's current Stakeholder Engagement Plan. Provider participation has been fostered in the same groups that are detailed in the response #2 to question 22. In addition, the GMCB has done significant outreach to providers about health care reform, payment reform initiatives with an emphasis on provider led change. (See Provider Outreach Activities Spreadsheet in appendix).

Key Artifacts:

Exhibit	Artifact	URL
87	GMCB Provider Outreach and Public Engagement	
81	GMCB Hospital Budget Guidance FY14-16	http://gmcboard.vermont.gov/sites/gmcboard/files/Hospital_Budget_Guidance_FY14-16.pdf
54	Blueprint for Health 2012 Annual Report	
	Payment Reform Pilot Applications	
125	St. Johnsbury Oncology Pilot	
121	CHAC (FQHCs and Bi-State)	
123	OneCare Vermont	
	Statutes and Legislation	
32	Act 48	http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
35	Act 171	http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT171.PDF
3	8 V.S.A § 4087	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04087
4	8 V.S.A. § 4088h	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04088h
10	18 V.S.A. § 706	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=013&Section=00706
16	18 V.S.A. § 9377	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09377

Section I	Quality, Financial and Health Goals and Performance Measurement Plan

This section of the Operational Plan is intended to provide information about the state's self-evaluation; endorsed performance measures; alignment across payers for the endorsed performance measures; and consumer, provider and payer buy-in during the process of selecting measures. It is also intended to provide a plan for quality performance target-setting, with a schedule for routinely assessing performance against targets and benchmarks.

Question 24. Has the state defined a common set of performance measures, consistent with endorsed measures (e.g. NQF, Meaningful Use, CMMI Core measure set), including quality, patient satisfaction, financial and health outcomes, aligned with existing quality initiatives?

Vermont has several payment and delivery system reform initiatives that are either in place or proposed. These initiatives fall under the categories of shared savings ACO, pay for performance, or episode of care payment models, and they are in varying stages of implementation. For each model, the maturity of performance measure development is dependent on the stage of implementation, but the process of identifying common measure sets is essentially the same for all models. It is a very thorough process under the auspices of the GMCB's Performance Measures Work Group, with opportunities for stakeholder input built into every step. As an example, it has taken from January 2013 until at least August 2013 to create a Medicaid and commercial insurer ACO measure set. This Work Group will be broadened under the Governance Structure described in section A of this plan, to incorporate the full scope of testing models and coordinate measure development with similar work on the duals demonstration model.

The measure development process involves:

- Convening work groups of interested stakeholders, including representatives of providers, consumers and payers, to establish criteria and develop the measure set
- Establishing measure criteria with stakeholders

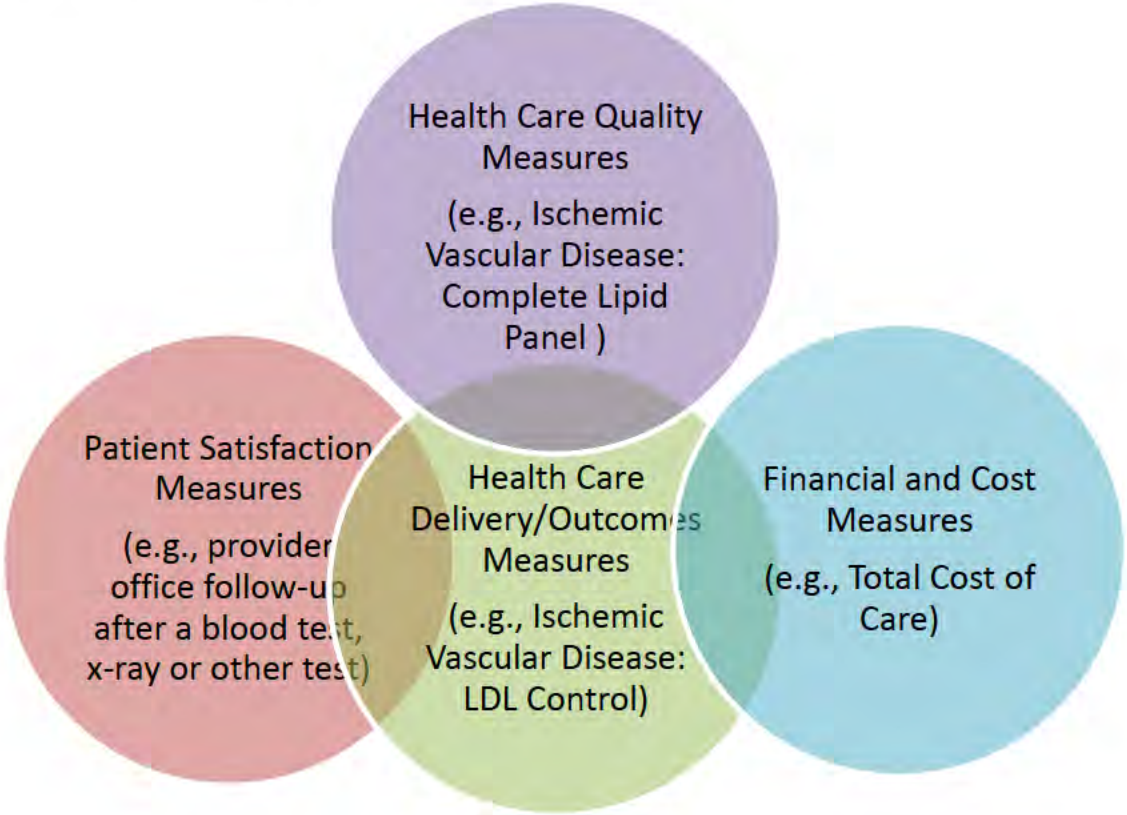
- Identifying potential measures with stakeholders, with a particular focus on measures that are endorsed and part of other measure sets (e.g. – NQF endorsed, CMMI Core Measure Set, meaningful use measures, HEDIS® or CAHPS® measures, measure sets in place for other state or national initiatives)
- Developing a crosswalk of potential measures with other measure sets, and reviewing crosswalk with stakeholders
- Evaluating potential measures against established criteria with stakeholders
- Finalizing the measure set with stakeholders
- Identifying data sources for each measures
- Determining how each measure will be used (e.g. – for payment vs. monitoring) with stakeholders
- Determining benchmarks (if available) and performance targets with stakeholders
- Determining reporting requirements and frequency with stakeholders
- Revisiting the measure set on a regularly-scheduled basis with stakeholders
- Seeking feedback and guidance on proposed measure sets from CMMI's evaluation contractor and with Vermont's independent evaluation contractor, when the contractors are available for consultation

The most mature measure sets are currently found in the Commercial and Medicaid ACO Shared Savings model and the Vermont Blueprint for Health model. The current Commercial and Medicaid ACO measures are found in the Excel Workbook containing Outcome Measures Selected from the Suggested CMS Core Measures List, Custom Outcome Measures Selected for ACO Payment or ACO Monitoring, and Custom Outcome Measures Selected for Health System Monitoring or Pending Status.

The Blueprint (which contains Pay for Performance elements and is part of CMMI's Multipayer Advanced Primary Care Practice demonstration project) conducts aggregate evaluation of expenditures, utilization, quality of health services, outcomes and patient experience of care at least annually, with results benchmarked against a comparison group of patients with primary care visits to practices that don't participate in the Blueprint. Practice profiles, which are benchmarked against other practices in the health service area and against statewide results, were initially released in the Summer of 2013 and will be sent to practices annually. Learning Collaboratives associated with the Blueprint also regularly collect data and assess performance. The Blueprint has also developed a clinical registry called DocSite that contains hundreds of measures for different conditions or programs (examples of conditions include asthma, diabetes, depression, opioid dependence, ADHD, hypertension, coronary artery disease and congestive heart failure).

In addition, the Northeastern Vermont Regional Hospital Oncology pilot project and the proposed Northwestern Vermont Medical Center Emergency Department pilot project have lists of proposed measures. Those measures can be found in the artifacts entitled "Northeastern Vermont Oncology Pilot Proposed Measure Set" and "Northwestern Medical Center's Emergency Department Pilot Project Application" (proposed measures section).

These measure sets encompass metrics in the four recommended domains: health care quality (including behavioral health), patient satisfaction, financial outcomes (cost savings), and health care delivery/outcomes (identified measurable evidence-based quality metrics that address care delivery, health outcomes and patient experience). The following graphic shows the four types of measures and an example of each.



Measure sets for Vermont's payment and delivery system reforms are used for a variety of purposes, including:

- Model evaluation (e.g., using measures related to cost, utilization, health outcomes or experience of care to evaluate whether payment and delivery system reform models are reducing growth in health care costs, improving health, and improving care)
- Payment reform (e.g., using results of measures on childhood immunization, adolescent well care visits, pediatric BMI screening, chlamydia screening in women, colorectal cancer screening, optimal diabetes care, avoidance of antibiotic treatment for adults with acute bronchitis, initiation and engagement of alcohol and other drug treatment, and follow-up after hospitalization for mental illness to determine whether commercial ACOs qualify for shared savings programs)
- Monitoring (e.g., using ACO-level measures of tobacco use assessment and cessation intervention, influenza vaccination, all-cause readmissions, screening for diabetics, ambulatory care sensitive admissions, screening for depression, adult weight screening and follow-up, and utilization to monitor ACO impact)
- Quality improvement (e.g., in Vermont's asthma learning collaborative, using practice-level results on measures related to "assessment of severity," "assessment of control" and "asthma action plans completed" to design interventions to improve asthma care; in Vermont's office-based opioid treatment learning collaborative, using practice-level results on measures related to "unstable patients seen weekly," "documentation of opioid dependence," "accessed Vermont prescription monitoring services" and "outside care coordination" to design interventions to improve office-based treatment)
- Provision of real-time clinical information to participating providers to improve patient care and drive delivery system transformation (e.g., using practice-level information from the Blueprint's DocSite clinical registry or reports on key hospital quality indicators from ACOs to identify patients in need of evidence-based services or to change hospital processes)

The Green Mountain Care Board's application process for Vermont payment and delivery system reform pilot proposals requires applicants to indicate how they will measure outcomes related to each pilot goal.

Question 25. Has state ensured that all payers are aligned across endorsed performance measures, including quality, patient satisfaction, financial and health outcomes (as well as with MSSP and CMMI recommended measures)?

Question 26. Was there provider, consumer and payer buy-in during process of selecting SIM performance measures?

There are three major mechanisms that Vermont uses to ensure that all payers are aligned across endorsed performance measures, and that there is provider, consumer and payer buy-in during the process of selecting SIM performance measures:

- Forming SIM payment and delivery system reform Work Groups that include the major payers in the state, provider representatives and consumer representatives;
- Including payer and provider representatives in Blueprint advisory groups and individual Blueprint-payer meetings; and
- Including payers in the Joint Insurers Work Group.

Work Group Processes

As part of payment and delivery system reform, Vermont has convened work groups of interested parties. Provider, consumer, and payer representatives have been included in all Performance Measures Work Groups and Evaluation Work Groups related to payment and delivery system reforms to date. We plan to follow this process for all SIM models and their associated performance measures.

To date, the Performance Measures Work Group has focused on aligning performance measures in the Commercial and Medicaid ACO model. Payers participating in the Performance Measures Work Group for the Medicaid and Commercial ACO model include Medicaid, Blue Cross Blue Shield of Vermont, and MVP Health Care. Their feedback has been critical in aligning proposed measures with other initiatives (including suggested CMMI and MSSP measures); clarifying measure specifications and potential data sources; and understanding federal, state and accreditation requirements of payers.

While much progress has been made on creating a systematic process for developing measure sets, and on aligning payers and obtaining stakeholder buy-in for the Commercial and Medicaid ACP measure set, the next step is to generalize this work to other types of payment reform

models, including Pay for Performance and Bundled Payment models. The Performance Measures Work Group will evolve to take on the role of developing model-specific measure sets for Pay for Performance and Bundled Payment models, in the same way that it has developed measure sets for the Commercial and Medicaid ACOs.

The newly formed Vermont SIM/Duals Steering Committee, which is now part of the SIM/Duals governance structure (see section A), also includes payer, provider and consumer representatives. The Steering Committee will have an opportunity to review measure sets as they are developed by the Performance Measures Work Group.

Blueprint Advisory Groups and Insurer Meetings

Another example of alignment in performance measures is through the Vermont Blueprint for Health, which includes payer and provider representatives on the Executive Committee, Payment Implementation Work Group, Expansion Design and Evaluation Work Group, and Analytic Work Group. The Blueprint holds individual meetings with each of the major payers to present evaluation data, obtain feedback on program design and operations, and discuss future direction for the program. In these venues, the various stakeholders have opportunities to provide feedback on measure sets, as well as other aspects of model implementation.

Joint Insurers Work Group

Payers are informed of earlier-stage payment reform models through the Joint Insurers Work Group that has been convened by the State; this group has met approximately bi-weekly for about two years. These meetings have provided a strong foundation for multi-payer support of Vermont's payment and delivery system reform models. The payers have not only agreed to participate in the models, they have been instrumental in helping the State design frameworks (including performance measures) for these models.

As an example, payers have proposed potential measures for the Oncology pilot project, and are actively engaged in refining that measure set. Primary care and specialist physicians have also directly participated in the Oncology pilot project design, including discussions of measure selection. They are represented on the Oncology Project steering committee and operations

committee. Care coordinators who directly serve patients with cancer and their families are also represented on these Oncology project committees.

Question 27. Is there a formal plan in place for quality performance target-setting with a schedule for routinely assessing current performance against targets/benchmarks?

Quality performance target-setting, development of benchmarks, and schedules for routine assessment of current performance against targets and benchmarks will be the purview of the Performance Measures Work Group and the SIM Evaluation Services contractor that is currently under recruitment in response to an RFP. The RFP for the Evaluation Contractor seeks a contractor who can assist in developing performance measures, benchmarks, and an evaluation process for the shared savings, pay for performance and bundled payment pilots that are approved by Vermont's GMCB. It also seeks a contractor that can provide overall evaluation of the SIM grant. The RFP references the need for measures of process; outcomes; patient, provider and caregiver experience; access to care; quality of care; reduction in the growth of health care expenditures; costs and other financial targets; and utilization.

As outlined above, the Performance Measures Work Group has made progress in creating a process for measure set adoption, and specifically in developing a measure set for the proposed Commercial and Medicaid ACO. That group will evolve to address other payment reform models.

The following Performance Measurement Plan shows activities that have already been implemented for the ACO shared savings payment reform project, as well as activities that need to be initiated.

Operational Area and Objectives	Implementation Action Items	Start Date	End Date	Responsible Parties	Milestones	Status
Performance Measures: Define common sets of performance measures	Convene work group, establish measure criteria, identify potential measures, crosswalk against existing measure sets, evaluate against criteria, identify data sources, determine how each measure will be used, seek input from CMMI and Vermont independent evaluation contractors, finalize measure set, identify benchmarks and performance targets, determine reporting requirements, revisit measure set on regular basis	1-1-13	Ongoing	GMCB Payment Reform Team, Work Group	Initial meeting held, measure criteria, list of potential measures, measure crosswalk, feedback from CMMI contractor, final measure set, benchmarks and performance targets, reporting specifications and schedule, schedule for measure review	Work group is meeting regularly, shared savings measure set will be completed during Q3 of 2013, next step in Q3 and Q4 will be to identify benchmarks, set targets, and determine reporting requirements
Performance Measures:	Include formal payer approval in	1-1-13	Ongoing	GMCB Payment Reform Team,	Process for payer approval	Payers currently included in

Ensure payer alignment across endorsed measures	performance measures workgroup			Work Group		consensus process in performance measures work group
Performance Measures: Ensure provider, consumer and payer buy-in during measure selection	Seek ideas for enhancing consumer input mechanisms, seek ideas for enhancing provider input mechanisms	9-1-13	Ongoing	GMCB Payment Reform Team, Work Group	Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in	Consumer and provider representatives currently included in performance measures work group; will implement additional mechanisms as appropriate in Q4
Performance Measures: Establish plan for target-setting with schedule for routine assessment	Build target-setting into performance measures workgroup and routine assessment into reporting requirements, develop analytic framework for routine assessment, create analytic reports	9-1-13	Ongoing	GMCB Payment Reform Team, Work Group, Analytics Contractor	Establish target-setting process, routine assessment process, and analytic framework and reports	These action items will be implemented for shared savings measures in Q3 and Q4 of 2013, and will be part of ongoing measure development for other payment reform projects

Future Work Related to Performance Measurement

For the three bundled payment Episodes of Care (EOC) projects slated for implementation beginning in October of 2014 (see Section P), measure set development will begin during the fourth quarter of calendar year 2013. The Performance Measures Work Group, in conjunction with the GMCB Payment/Delivery System Reform Team and the CMMI and Vermont independent evaluation contractors, will lead that work according to the following timeline:

- Establish measure criteria (November 2013)
- Identify potential measures (December 2013 through February 2014)
- Crosswalk against existing measure sets and evaluate against criteria (March and April 2014)
- Identify data sources and determine how each measure will be used (May and June 2014)
- Finalize measure set and measure uses (July 2014)
- Determine benchmarks and performance targets (August 2014)
- Determine reporting requirements and reporting frequency (September 2014)
- Revisit measure set on annual basis (September 2015 and 2016)

Please note that while timelines for developing and implementing performance measures may vary for individual EOC projects based on project start dates, the activities outlined above will occur for all projects. A crucial element for success -- the formation of cohesive stakeholder groups and the resulting relationship-building needed to provide momentum for complex payment and delivery system transformation -- is very well-established in Vermont.

Key Artifacts:

- Performance Measures Work Group and Patient Experience Survey Subgroup membership, meeting schedules, meeting agendas, meeting summaries, measures crosswalks, proposed commercial and Medicaid ACO measure sets
- Blueprint Annual Report (Evaluation and Health Information Technology sections)
- Blueprint Clinical Registry (DocSite) Data Dictionary
- Blueprint Practice Profile template
- Blueprint Practice Profile Supporting Documentation
- OneCare application (Outcomes Measurement and Clinical Model sections)

- Northeastern Vermont Oncology pilot project Steering Committee and Operations Committee membership, meeting agendas, meeting summaries and proposed measure set
- Northwestern Medical Center's Emergency Department pilot project application (proposed measures)
- Community Health Accountable Care application (Outcomes Measurement section)
- Rutland Regional Medical Center CHF Bundled Payment application (pages 10, 13, 19-30)
- Membership, meeting agendas, meeting summaries, and supporting materials for Blueprint work groups
- SIM Steering Committee membership
- Excel Workbook containing Outcome Measures Selected from the Suggested CMS Core Measures List, Custom Outcome Measures Selected for ACO Payment or ACO Monitoring, and Custom Outcome Measures Selected for Health System Monitoring or Pending Status in the requested format
- Vermont SIM Evaluation RFP
- Crosswalk of CMMI recommended population level measures that are being collected by the Vermont Department of Health

Responses to specific CMMI Guidance for Section I

I.1 Describe how self-measurements will be used

Instructions: This section allows you to describe how you will use your measurements for your own self-improvement. How will data from the measurements be used to rapidly learn, identify, test and implement changes? What other uses do you anticipate? (Max 500 chars)

Measure sets will be used in Vermont for a variety of purposes, including model design and evaluation, payment reform, monitoring, quality improvement, and provision of real-time clinical information to participating providers to improve patient care and drive delivery system transformation (see above for examples). Performance measures also are used in Vermont's learning collaboratives, to assess baseline performance, evaluate results of interventions, and inform project design. More information about existing learning collaboratives can be found in Section M of this Operations Plan.

I.2 Programmatic and Operational Domains

Instructions: Each quarterly report will require some basic information regarding programmatic and operational progress. Please complete the table by noting any limitations (or "Not Applicable") you may have with these areas.

Domain	Limitations
Accomplishments	Not Applicable
Planned Activities for the Next Quarter and Likelihood of Achievement	Not Applicable
Substantive Findings	Some measures that are based on medical records, including electronic medical records, may be challenging to produce in the short term. Vermont has significant initiatives underway to develop health information exchange capacity, the necessary interfaces, and improvement in data quality that will eventually allow the capture of accurate, reliable information for clinical use, as well as for evaluation and testing of payment reform models.
Findings from Self-Evaluation	In the initial phases of Vermont's SIM Testing grant, the self-evaluation will rely more heavily on claims-based measures and already existing data collection efforts to develop baseline results. Over time, clinical data should become more robust and there should be enhanced capacity to link changes over time to the payment reform models being implemented as part of the SIM Testing Grant.
Work Breakdown Structure	Not Applicable

I.3 and I.4 Outcome Measure Selection from Suggested CMS Core Measures and Custom Outcome Measures

As discussed above, the most mature measure sets are currently found in Vermont's Commercial and Medicaid ACO Shared Savings model and the Vermont Blueprint for Health model.

An Excel workbook has been developed that reflects the current status of Vermont's Medicare, Medicaid and Commercial Shared Savings model measures, using the format contained in CMMI's State Innovation Model Operational Plan Guidance. There are separate worksheets for Outcome Measures Selected from the Suggested CMS Core Measures List, Custom Outcome Measures Selected for ACO Payment or ACO Monitoring, and Custom Outcome Measures Selected for Health System Monitoring or Pending Status. That workbook is attached.

Vermont's OneCare ACO and Community Health Accountable Care have proposed performance measurement approaches in their applications to the GMCB.

The Blueprint for Health Annual Report, clinical registry data dictionary, and Practice Profiles demonstrate that program's significant measurement activity.

A list of proposed measures for Vermont's Oncology Pilot Project has been developed by the payers, providers and care coordinators that participate in the project; those measures can be found in the attached document entitled Proposed VOP Measures. In addition, the proposed Northwestern Vermont Medical Center Emergency Department pilot project has a list of proposed measures, and the CMMI application for the Rutland Regional Medical Center CHF bundled payment project describes that project's performance measurement approach.

Additional measures will be developed during the testing period and as new projects are implemented, with assistance from Vermont's SIM Evaluation contractor, and CMMI's evaluation contractor.

Key Artifacts:

Exhibit	Artifact	URL
	Performance Measures Work Group	
28	ACO Measures Work Group Meeting Agendas and Minutes	
29	ACO Standards Work Group Meeting Agendas and Minutes	
146	Status of MSSP Measures (2/4/2013 Meeting)	
27	ACO Measure Set Overview Presentation (7-15-2013)	
26	ACO Commercial Measures Set Overview (6/2/2013)	
30	ACO Tentative Measures Set (4/2/2013)	
31	ACO Tentative Measures Set (5/16/2013)	
	Blueprint	
54	Blueprint 2012 Annual Report (Evaluation and Health Information Technology sections)	
60	Blueprint Practice Profile template	
61	Blueprint Practice Profile Supporting Documentation	
46	***Blueprint Clinical Registry (DocSite) Data Dictionary***	
	Suggested Changes	
	Primary Care	
	Performance Dashboard	
	New Measure Sets	
	SASH	
	Tobacco Cessation	
	Community Health Team	
55	**Blueprint for Health Executive Committee and Analytic and Evaluation Working Group Meeting Agendas and Minutes**	
	Executive Committee Agendas (4/9)	
	Executive Committee Agendas (5/15)	
	Executive Committee Minutes (4/9)	
	Analytic and Evaluation WG Agenda (5/22)	
	Analytic and Evaluation WG Members	
	Vermont Oncology Pilot	
181	VOP Annual Report	

182	VOP Annual Report Presentation for GMCB	
188	VOP Steering Committee Membership	
183	VOP Meeting Materials (Agendas, Minutes, Notes)	
189	VOP Steering Committee Meeting Presentation	
184	VOP Operations Committee Meeting Presentation	
187	VOP Proposed Measures	
185	VOP Participating Organizations and Providers	
186	VOP Primary Care Contact List	
180	VOP 2012 Milestones	
	Additional Applications	
122	Northwestern Medical Center's Emergency Department Pilot Project Application	
121	Community Health Accountable Care application (Outcomes Measurement section, p. 11)	
124	Rutland Regional Medical Center Bundled Payment Application	
	Outcome Measures	
117	Outcome Measure Selection from Suggested CMS Core Measures List	
116	Outcome Measure Selection - ACO Payment or ACO Monitoring	
118	Outcome Measure Selection - Health System Monitoring or Pending Status	
143	SIM Steering Committee membership	http://gmcboard.vermont.gov/sim_grant/members

Section J Appropriate Consideration for Privacy & Confidentiality

This section provides information regarding Vermont's policies and procedures around privacy and confidentiality.

Question 28. What are the special protections related to diagnoses, conditions, and populations with privacy and confidentiality concerns?

Recognizing that the integration of care will require information-sharing across medical, behavioral and other settings, Vermont has a number of legal and regulatory structures in place that can be incorporated into its Operational Plan for Model Testing. These are described below:

Vermont Law on Patient Consent

Vermont law is stricter than the HIPAA Rule because it requires individual consent for a health care provider to make disclosures of information gathered and maintained for treatment of the patient. For example, the patient privilege statute, 12 V.S.A. § 1612, prohibits physicians, chiropractors, dentists, nurses, mental health providers (and by implication the organizations who maintain their records) from disclosing protected health information without the patient's consent or an express requirement of law. The Hospital Patient Bill of Rights, 18 V.S.A. § 1852(7), and the Nursing Home Resident Bill of Rights, 33 V.S.A. § 7301(2)(H), also require individual patient or resident consent prior to the disclosure of protected health information beyond those providing care at the relevant facility. Under the mental health care provisions, 18 V.S.A. § 7103(a), no disclosure may be made of the protected health information relating to an individual or to the individual's identity without the individual's written consent. Similarly, no protected health information which includes the results of genetic testing or the fact that an individual has been tested shall be disclosed without the written consent of the individual under 18 V.S.A. § 9332(e). Drug test results subject to Vermont's drug testing law set forth in 21 V.S.A. § 516(a)-(b) may not be disclosed except as provided in the statute or with the written consent of the individual.

AHS HIPAA Privacy Protections for Personally Identifiable Health Information (PHI)

AHS has adopted a set of HIPAA Standards & Guidelines implementing the HIPAA Privacy Rule and governing the agency's receipt and handling of PHI. All AHS employees are required to comply with the Standards & Guidelines. *See* http://intra.ahs.state.vt.us/hipaa/hipaa-standards-and-guidelines. AHS also maintains HIPAA guidance and information for patients, providers, and researchers. *See* http://humanservices.vermont.gov/policy-legislation/hipaa/

Department of Information & Innovation (DII) Policies

DII has promulgated policies that apply to all state agencies and departments governing security, hardware and media disposal, and information security best practices. *See* http://dii.vermont.gov/Policy_Central

Vermont Health Information Technology Plan (VHITP)

Under 18 V.S.A. § 9351(a), the plan "shall include the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients." It must incorporate "standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in Vermont." *Id.* Among other specific statutory requirements, the plan must "ensure the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols" and "address issues related to data ownership, governance, and confidentiality and security of patient information." 18 V.S.A. § 9351(b).

Vermont law also requires that "[t]he privacy standards and protocols developed in the statewide health information technology plan shall be no less stringent than applicable federal and state guidelines, including the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments, and the privacy provisions established under Subtitle D of Title XIII of Division A of the American

Recovery and Reinvestment Act of 2009, Public Law 111-5, sections 13400 et seq. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail." 18 V.S.A. § 9351(e).

The VHITP was developed with these legal requirements in mind. Indeed, the first "core value" in the plan itself states that "Vermonters will be confident that their health care information is secure and private and accessed appropriately." *See* VHITP at 7, *available at* http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf To that end, Vermont Information Technology Leaders (VITL),[3] the designated health information exchange (HIE) for the state and a key collaborator on the creation and revision of the VHITP, conducted statewide outreach and developed a set of privacy and security policies to govern Vermont's HIE. *See* VHITP at 55-58 (describing development of privacy and security policies governing Vermont's Health Information Exchange); VITL Policies and Procedures Governing Vermont's Health Information Exchange, *available at* http://www.vitl.net/health-information-exchange/policies-procedures. *See also* VHITP at 79 (Appendix B), "Application of Law to the Privacy and Security Framework of a Health Information Exchange Network". VITL's policies include: Policy on Participating Health Care Provider Policies and Procedures for the VHIEN, Policy on Patient Consent to Opt In to VHIEN, Policy on Secondary Use of Identifiable PHI on VHIEN, Policy on Information Security, Policy on Privacy and Security Events, and Policy on Auditing and Access Monitoring. The Policy on Patient Consent uses an opt-in model because Vermont law is stricter that HIPAA in requiring patient consent, as discussed above.

Further, as the Plan describes, any organization participating in Vermont's HIE must sign business associate agreements spelling out in detail how data is to be used between organizations. No technical work can begin on an project or interface until those agreements have been signed by all parties. *See* VHITP at 57.

Finally, in the event providers, individuals, or others fail to comply with state or federal law or policy regarding privacy, Vermont law provides several compliance mechanisms:

- 18 V.S.A. § 9437(8): In order to obtain a Certificate of Need, a permit from the state to develop a new HIT project with annual operating expense of more than $500,000 for either of the next two budgeted fiscal years, the applicant must show that the project conforms to the VHITP.

[3] VITL's mission is to collaborate with all stakeholders to expand the use of secure health information technology to improve the quality and efficiency of Vermont's health care system. VITL is both the designated HIE for the state of Vermont and the federally-designated regional extension center for the state of Vermont.

- 18 V.S.A. § 9352(h): VITL is authorized to require that HIT systems acquired under a VITL grant or loan comply with data standards for interoperability adopted by VITL and the VHITP.
- 18 V.S.A. § 9352(i): VITL, following federal guidelines and state policies, if enacted, is authorized to certify the meaningful use of HIT and electronic health records by health care providers licensed in Vermont. Without meaningful use certification, providers will not qualify for the Medicaid incentives created in the ARRA/HITECH act.

Statutes, regulations, and policies governing the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database

To the extent allowed by HIPAA, the Vermont Legislature has authorized the state (formerly DFR, now the Green Mountain Care Board) to collect health care eligibility and medical and pharmacy claims data from health insurers to be available as a resource for insurers, employers, providers, purchasers of healthcare, and state agencies in order to review health care utilization, expenditures, and performance in Vermont. 18 V.S.A. § 9410 (creating VHCURES); Vt. Gen. Assembly Act No. 79 (2013), § 40 (amending 18 V.S.A. § 9410 to move responsibility for VHCURES from the Department of Financial Regulation to the Green Mountain Care Board, effective on passage). Notwithstanding HIPAA or any other provision of law, Vermont law prohibits the public disclosure of any data from VHCURES that contains direct personal identifiers, e.g., information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number. 18 V.S.A. § 9410(h)(3)(D). Further, any person who knowingly fails to comply with data confidentiality requirements for VHCURES data is subject to administrative penalties of up to $50,000 per violation, 18 V.S.A. § 9410(g), in addition to any federal enforcement.

Regulation H-2008-01 sets out the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the state for use in VHCURES. The Regulation also contains conditions for the use and dissemination of such claims data, as required by and consistent with the purposes of 18 V.S.A. § 9410. In particular, Section 8 (Procedures for the Approval and Release of Claims Data) lays out the requirements, procedures and conditions under which persons other than the Board may have

access to health care claims data sets and related information received or generated by the state. Such access depends upon the nature of the requestor and the characteristics of the particular information requested. Appendix J of the Regulation classifies all data elements in the VHCURES database as either unrestricted (available for general use and public release), restricted (available only as part of a Limited Use Research Health Care Claims Data Set approved by the Board pursuant to the Regulation), or unavailable (not available for use or release outside the Board under any circumstances).

Vermont recently updated its VHCURES Policies and Procedures Manual for Data Release, Security, and Protection (VHCURES Manual) related to VHCURES to conform Vermont's practices to Data Use Agreement for Medicare data currently pending approval by CMS. *See* VHCURES Manual, Attachment 2. For example, Vermont has generated new tracking and accountability forms to meet CMS's standards as well as DII's standards. *See* VHCURES Manual, Attachment 6 (Hardware Chain of Custody Form), Attachment 7 (Certificate of Disposition).

Guidance Concerning Privacy and Security for Vermont Blueprint for Health and Other Providers

DVHA and the Blueprint recently developed this guidance document.[4] It includes information related to data sharing with business associates, patient consents, patient authorizations, and general patient information that practices may use to assist providers and others in complying with the state and federal privacy laws. It is intended for all Vermont Blueprint for Health practices whether or not they have implemented an electronic health record system or intend to use the Vermont HIE or the statewide clinical registry. The guidance document recognizes that HIPAA and the federal regulations governing the confidentiality of alcohol and drug abuse patient records (42 C.F.R. Part 2) contain mechanisms that allow programs to disclose information without the patient's consent to outside organizations that provide services to the program or to the program's patients.

OneCare Vermont Accountable Care Organization

OneCare is a statewide Track 1 Medicare Shared Savings Program created by Fletcher Allen Health Care and Dartmouth Hitchcock Medical Center and approved by CMS in January 2013. Section Ten of OneCare's application to CMS presents a strategy for data sharing, security, and privacy that will enable data to flow securely between ACO participants. The application

[4] The Blueprint Guidance document is currently in "Draft" form because the templates and examples for the final Appendix is still being developed. The content of the document is substantively complete.

identifies the Northern New England Accountable Care Collaborative Data Trust as the initial recipient of data from CMS. The Trust then transmits the data to FAHC and DHMC. As the application explains, all three entities have significant experience with and infrastructure for handling data securely. The application also states that OneCare will comply with all privacy and security specifications in the CMS Data Use Agreement and all HIPAA regulations. OneCare will also comply with CMS's data suppression policy in all analyses and presentation to external parties. *See* OneCare Vermont MSSP ACO Application – Section 10 Question 32.

Vermont has a robust array of privacy and data security protections in place, in law, regulation, and policy. The state will leverage these assets as it undertakes this planned transformation by applying them and, where necessary, revising them, to ensure that the privacy of PHI is maintained at all times and to promote the secure, efficient flow of data.

Key artifacts:

Exhibit	Artifact	URL
37	AHS HIPAA Standards & Guidelines	http://intra.ahs.state.vt.us/hipaa/hipaa-standards-and-guidelines
36	AHS HIPAA guidance and information for patients, providers, and researchers	http://humanservices.vermont.gov/policy-legislation/hipaa/
	Information Technology Privacy Policies	
67	Department of Information and Innovation (DII) Policies	http://dii.vermont.gov/Policy_Central
165	Vermont Health Information Technology Plan (VHITP)	http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf
178	VITL Policies & Procedures	http://www.vitl.net/health-information-exchange/policies-procedures
173	VHCURES Policies and Procedures Manual for Data Release, Security, and Protection (Rev. May 2013)	
	Statutes	
6	12 V.S.A. § 1612 (patient privilege)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=12&Chapter=061&Section=01612
8	18 V.S.A. § 1852 (Hospital Patient Bill of Rights)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=042&Section=01852
11	18 V.S.A. § 7103 (disclosure of information related to mental health care)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Ch

		apter=171&Section=07103
12	18 V.S.A. § 9332 (disclosure of information related to genetic testing)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=217&Section=09332
14	18 V.S.A. § 9352 (VITL)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=219&Section=09352
19	18 V.S.A. § 9437 (certificate of need criteria)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09437
20	21 V.S.A. § 516 (confidentiality of drug testing information)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=21&Chapter=005&Section=00516
25	33 V.S.A. § 7301 (Nursing Home Resident Bill of Rights)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=073&Section=07301
13	18 V.S.A. § 9351	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=219&Section=09351
34	18 V.S.A. § 9410, as amended by Act 79 of 2013, § 40	http://www.leg.state.vt.us/docs/2014/Acts/ACT079.pdf
129	Regulation H-2008-01 (VHCURES)	http://gmcboard.vermont.gov/sites/gmcboard/files/REG_H-2008-01.pdf

Section K Staff/Contractor Recruitment and Training

This section describes the process for developing a comprehensive staffing and contractor plan for implementing Vermont's SIM initiative. We anticipate completion of this detailed plan by early Fall 2013. As described below, we will rely on a combination of State staff and contractors to perform the tasks required for a successful SIM Project.

Question 29. How the state has or will recruit new/additional staff and/or contractors (as budgeted in SIM application) to adequately support SIM activities.

Question 30. How the state has or will recruit new/additional staff and/or contractors (as budgeted in SIM application) to adequately support SIM activities 2.

Question 31. How the state has trained all new and existing staff or contractors to fulfill their roles and defined supports for ongoing workforce development to ensure support of SIM activities throughout the grant period.

Resource Plan Overview

Due to the comprehensive nature and broad scope of VT's SIM, the state will rely on a mix of existing and new staff and contractors to implement and evaluate the success of initiatives planned during the testing period. As described in Section A of this Operation Plan, Vermont intends to run the SIM Project as a public/private partnership. This partnership also will be reflected in our staffing and contracting plans.

The roles and responsibilities between the co-leading organizations, the Department of Vermont Health Access (DVHA) and the Green Mountain Care Board (GMCB) will be finalized in a Memorandum of Understanding (MOU). Similarly, any positions or contracts funded through the grant but located in different agencies, will also have a MOU with either DVHA or GMCB.

Any changes to the SIM-funded staffing and contract plans will be reviewed and approved by the SIM Core Team.

Staffing and Recruitment Plan

The State staff involved in the SIM Project work in five state agencies: the Agency of Administration, the Green Mountain Care Board, the Agency of Human Services, the Department of Vermont Health Access, and the Department of Aging and Independent Living. In a matrixed staffing approach, the SIM Project staff will work under the general direction of the SIM Project Director who resides in the Agency of Administration. The table below provides a summary of positions currently working on the SIM grant. Additional staff will be hired in the coming months.

Recruitment for staff is underway and includes advertising in print and web-based job boards and special notice on state websites. Due to the specialized skills and small population and rural predominance of the state, timely recruitment of qualified staff is an identified challenge and the SIM leadership and operations staff are closely monitoring and putting resources towards these efforts. Vermont expects all SIM Project staff to be hired by November 2013.

Staff training, capacity building activities and organizational change management will be multi-faceted and be phased-in over the course of the grant period. Initially for SIM funded staff, training will occur by leveraging technical assistance resources, webinars, and conferences as well as direct mentorship by the SIM project leadership. For broader state staff training, a set of educational slides about the care delivery and payment models planned under SIM are under development and will be presented both informally via “lunch and learns” and formally at appropriate state staff events. These slides will also be posted on a state website. As the models prepare for launch, more in-depth webinars and materials will be developed; these activities are included in the operational plans (see Section P).

Staff Evaluation and Sustainability

Initially, the focus of SIM-funded staff will be activating the full governance and management structure described in section A and on finalization of model design and implementation of the models with an emphasis on helping to accelerate and expand ongoing efforts. SIM staff will be evaluated using the State's well-defined process for providing feedback and performance review. As the models mature and as the grant period comes to a close, the SIM funded staff will transition their focus from implementation and to training existing State staff and building their capacity to transform their roles and responsibilities to support the new care and payment delivery models identified as successful under the test period. In addition, a contractor will be hired to do an assessment and make recommendations on reorganization of current state organizations in light of the new systems and models.

Key State Personnel Please list the State staff who are assigned to SIM				
Name	**Organization/Title**	**SIM Role**	**Supervisor**	**Amount of time funded through SIM**
Anya Rader Wallack, Ph.D.	Agency of Administration/Governor's Office	Core team chair (on contract)	Governor	0%
Robin Lunge	Agency of Administration/Governor's Office, Director of Health Care Reform	Core team member	Secretary of Administration	0%
Doug Racine	Agency of Human Services, Secretary	Core team member	Governor	0%
Mark Larson	Department of Vermont Health Access, Commissioner	Core team member	Doug Racine	0%
Al Gobeille	Green Mountain Care Board, Chair	Core team member	NA	0%
Susan Wehry, Commissioner	Department of Disabilities, Aging and Independent Living, Commissioner	Core team member	Doug Racine	0%

To be hired	Agency of Administration, Project Director	Project Director	Anya Rader Wallack/Core Team	100%
Paul Dupre, Commissioner	Department of Mental Health, Commissioner	Steering Committee Member	Doug Racine	0%
Harry Chen, Commissioner	Department of Health, Commissioner	Steering Committee Member	Doug Racine	0%
Dave Yacavone, Commissioner	Department for Children and Families, Commissioner	Steering Committee Member	Doug Racine	0%
Stephanie Beck, Director of Health Care Operations, Compliance & Improvement	Agency of Human Services, Director of Operations	Steering Committee Member	Doug Racine	0%
Richard Slusky	Green Mountain Care Board, Director of Payment and Delivery System Reform	SIM Project Manager	Al Gobeille	25%
Kara Suter	Department of Vermont Health Access, Director of Payment Reform	SIM Project Manager	Mark Larson	25%
Georgia Maheras	Green Mountain Care Board, Executive Director	Project Fiscal and Grant Manager	Al Gobeille	0%
Kate Jones	Department of Vermont Health Access, Business Manager	Project Fiscal and Grant Manager	Mark Larson	0%
Karen Hein, M.D.	GMCB Member	Work Group co-chair	NA	0%

Erin Flynn	DVHA, Program Specialist	Program Specialist	Kara Suter	100%
Luann Poirier	DVHA, Project Administrator	Project Administrator	Kara Suter	100%
Ena Backus	GMCB, Health Care Administrator	Work Group Staff	Richard Slusky	0%
Spenser Weppler	GMCB, Health Care Administrator	Work Group Staff	Richard Slusky	0%
Pat Jones	GMCB, Policy Director	Work Group Staff	Richard Slusky	0%
Steve Maier	DVHA, Director of Health Care Reform	Work Group Staff	Mark Larson	0%
Christine Geiler	GMCB	Grants & Stakeholder Coordinator	Georgia Maheras	100%

The table below details additional staff anticipated to be hired under the grant.

SIM Positions to Be Filled

Position	SIM Role	Anticipated Date of Hire	Salary	Recruiting strategy
Service Delivery Specialist (ICS)	AHS – Core Staff	7/31/13	$43,722	State of VT HR website / Newspaper / UVM website
Fiscal Manager	AHS / Finance – Core Staff	7/31/13		State of VT HR website / Newspaper / UVM website
Fiscal Manager	DVHA / AHS – Core Staff	7/31/13		State of VT HR website / Newspaper / UVM website
Payment Program Director (P4P / Episodes)	DVHA / AHS – Core Staff	7/31/13	$63,066	State of VT HR website / Newspaper / UVM website

Payment Program Manager (ICS)	DVHA / AHS – Core Staff	7/31/13	$55,619	State of VT HR website / Newspaper / UVM website
Payment Program Director (ACO)	DVHA / AHS – Core Staff	7/31/13	$63,066	State of VT HR website / Newspaper / UVM website
SIM Evaluation Manager	Green Mountain Care Board – Core Staff	7/31/13		State of VT HR website / Newspaper / UVM website
Data Analyst	DVHA / AHS – Core Staff	7/31/13	$49,150	State of VT HR website / Newspaper / UVM website
Data Analyst	DVHA / AHS – Core Staff	7/31/13	$49,150	State of VT HR website / Newspaper / UVM website
Data Analyst	DVHA / AHS – Core Staff	7/31/13	$49,150	State of VT HR website / Newspaper / UVM website
Data Analyst	DVHA / AHS – Core Staff	7/31/13	$49,150	State of VT HR website / Newspaper / UVM website
Service Delivery Specialist	DVHA / AHS – Core Staff	7/31/13	$43,722	State of VT HR website / Newspaper / UVM website
Quality Monitoring / Evaluation Manager	DVHA / AHS – Core Staff	7/19/13	$58,947	State of VT HR website / Newspaper / UVM website
Quality Monitoring / Evaluation Manager	DVHA / AHS – Core Staff	7/31/13	$58,947	State of VT HR website / Newspaper / UVM website
Payment Program Manager (P4P)	DVHA / AHS – Core Staff	7/31/13	$49,150	State of VT HR website / Newspaper / UVM website

Payment Program Manager (Episodes)	DVHA / AHS – Core Staff	7/31/13	$49,150	State of VT HR website / Newspaper / UVM website
Payment / Policy Specialist	DVHA / AHS – Core Staff	7/31/13	$43,722	State of VT HR website / Newspaper / UVM website

Contractor Plan

Vermont has identified the key contracting categories, as described in our Year One Budget Narrative submitted on July 31, 2013, to support the Project and anticipate a detailed contracting plan by early Fall 2013. During the course of Operational Plan development, Vermont began to identify priority contracts that will ensure all Project timelines and milestones are met. This work will continue in the second quarter of the SIM Project. SIM staff will develop a contracting plan that will reflect all of the contracts needed to achieve the timeline and milestones identified in this Operational Plan. The contracting plan will include basic scopes of work and a process for developing Requests for Proposals and contracts that meet the SIM Project needs.

The table below summarizes contracts executed to date related to this project.

Key Contractors Please list the contractors involved in SIM				
Name	**Organization**	**SIM Role**	**State Supervisor**	**Source of Funding if other than SIM**
Susan Besio	Pacific Health Policy Group (PGPG)	Duals Alignment; Value-based Purchasing Plan Development	AHS/DVHA	Duals Project Funding
Mark Prodrazik	Burns and Associates	Medicaid Payment Reform Support; Medicaid ACO SSP Development Support	DVHA/GMCB	GMCB Payment Reform Project Funding
Brendan Hogan	Bailit Health Purchasing	Duals Alignment	DVHA	Duals Project Funding
Michael Bailit	Bailit Health Purchasing	ACO Standards and Quality Metric Development	GMCB	GMCB Payment Reform Project Funding

Artifacts:

Exhibit	Artifact	URL
68	DHR Guide to Performance Management	http://humanresources.vermont.gov/sites/dhr/files/Documents/Labor%20Relations/DHR-Guide_Performance_Management.pdf
138	SIM Milestone Timeline (2013-2016)	

Section L Workforce Capacity Monitoring

This section addresses Vermont's efforts around ensuring an adequate workforce to deliver care once the payment and delivery system reforms are complete.

32. Has the State designed, planned and begun to implement a program to address the future healthcare workforce requirements of its proposed innovation model, consistent with the objectives established by HRSA?

The State has designed, planned and begun to implement a program to address the future healthcare workforce needs. Act 48 Section 12a directed the State's Director of Health Reform to develop a workforce strategic plan. Working for nearly a year, the Director engaged in-state and external stakeholders to craft a plan and recommendations for approval by the Green Mountain Care Board. On January 9, 2013, the Green Mountain Care Board approved the Health Care Workforce Strategic Plan (see list of artifacts below) which outlines the recommendations to be accomplished in conformance with both Vermont's comprehensive health reform law, Act 48, and HRSA's workforce objectives. The Plan was subsequently reviewed and accepted by the key legislative health committees during the session that ended in May. The Plan is divided into four main sections, each with recommendations and indicators of success outlined. These are:

1. Oversight and Planning for Workforce development with 3 recommendations and 11 sub-recommendations;
2. Recruitment and Retention of the Workforce with 3 recommendations;
3. Improving, Expanding, & Populating the Workforce Educational Pipeline with 11 recommendations; and
4. 3 recommendations to the Green Mountain Care Board and the Blueprint for Health for their assistance in supporting the Plan's implementation.

The Plan also outlines current workforce capacity issues and calls for ongoing workforce assessments through surveys of all health professions as part of licensure and through the

development of Vermont-appropriate metrics for determining supply and demand. In fact, the Vermont legislature passed Act 79 (included among artifacts) that makes the completion of health profession surveys a mandatory part of licensure. This was a major recommendation in the Health Care Workforce Strategic Plan. The surveys are being developed as each profession comes up for their licensure renewal. Next up will be dentists in August. The complete licensure renewal schedule from the Office of Professional Regulation is attached as an artifact.

In addition to these surveys, another useful and timely document that will be utilized to assess need is the annual statewide report of the primary care workforce conducted by the Area Health Education Centers in Vermont. The 2012 report is included among the artifacts.

The first step in implementing our Health Care Workforce Strategic Plan has been to form a permanent Workforce Work Group with Stakeholders from the health professions and key institutions and state agencies, as called for in the first recommendation in the Plan. The Workforce Work Group is one of the working groups described in Section A, Governance of the Operational Plan. The Workforce Work Group will be guided charter outlining the key workforce components of the Workforce Plan and the SIM project that it will oversee and monitor, including the following:

- Development of surveys for all licensed professions using national minimum data sets if available to assess supply.
- Development of metrics that define demand and help determine the workforce needs across the state.
- Coordination between and among external Stakeholders and all state agencies that influence workforce in education & training, recruitment, and promotion of health professions.
- Development and analysis of supply, demand, and performance measures utilizing a team of data analysts, workforce experts, facilitators, and researchers that reach out to all health professionals across the state.

The Governor is issuing an Executive Order to appoint the Workgroup at the end of July. The academic medical centers serving Vermont and the State College system have committed to participating. The Work Group will include representatives of:

UVM College of Medicine
Fletcher Allen Health Care
Dartmouth Hitchcock Medical Center
Agency of Administration
Department of Labor
Department of Education
VT Department of Health
Office of Professional Regulation
Vermont State Colleges
Primary Care Physicians
Specialty Care Physicians
Hospitals
Federally Qualified Health Centers
Home Health Agencies
RNs/LPNs
Nurse Practitioners
Physician Assistants
Community Mental Health Agencies
Allied Health Professionals
Pharmacists
Mental Health/Substance Abuse Providers
Blueprint for Health
Complementary/Alternative Medicine
Area Health Education Centers

In implementing the Workforce Plan, we will build on the expertise and experience of the wide variety of health professional training and education programs offered throughout the state. Those offered in the State College System and at the University of Vermont are outlined in the artifacts below. In terms of State employment training programs, the Vermont Department of Labor was directed by the Legislature to develop a comprehensive review of all such programs offered by each agency/department of state government. This assessment, due by the end of 2013, will be important in guiding consideration of increasing offerings for direct service and community health workers, an identified interest of our Blueprint for Health and the SIM project.

Key Artifacts:

Exhibit	Artifact Name	URL
93	Health Care Workforce Strategic Plan	http://hcr.vermont.gov/sites/hcr/files/workforce_Final%20Draft%20011520 13_mm.pdf
167	The Vermont Primary Care Workforce: 2012 Snapshot	http://www.uvm.edu/medicine/ahec/documents/AHEC_PCREPORT_1_16.pdf
38	APRN Task Force Final Report (2008)	
111	Naturopathic Physicians Prescribing Report	
89	Green Mountain Care Board Minutes, January 9, 2013	http://gmcboard.vermont.gov/sites/gmcboard/files/10913minutes.pdf
69	Executive Order (DRAFT) Health Care Workforce	
34	Act 79 (Sections 43-44, pp. 80-81)	http://www.leg.state.vt.us/docs/2014/Acts/ACT079.pdf
191	Workforce Capacity Programs/Curricula (State/Community Colleges & the University of Vermont)	
44	Biennial License Renewal Schedule: 2014-2015 (Office of Professional Regulation)	
113	Office of Professional Regulation Renewal Dates and Forms	

Section M Care Transformation Plans

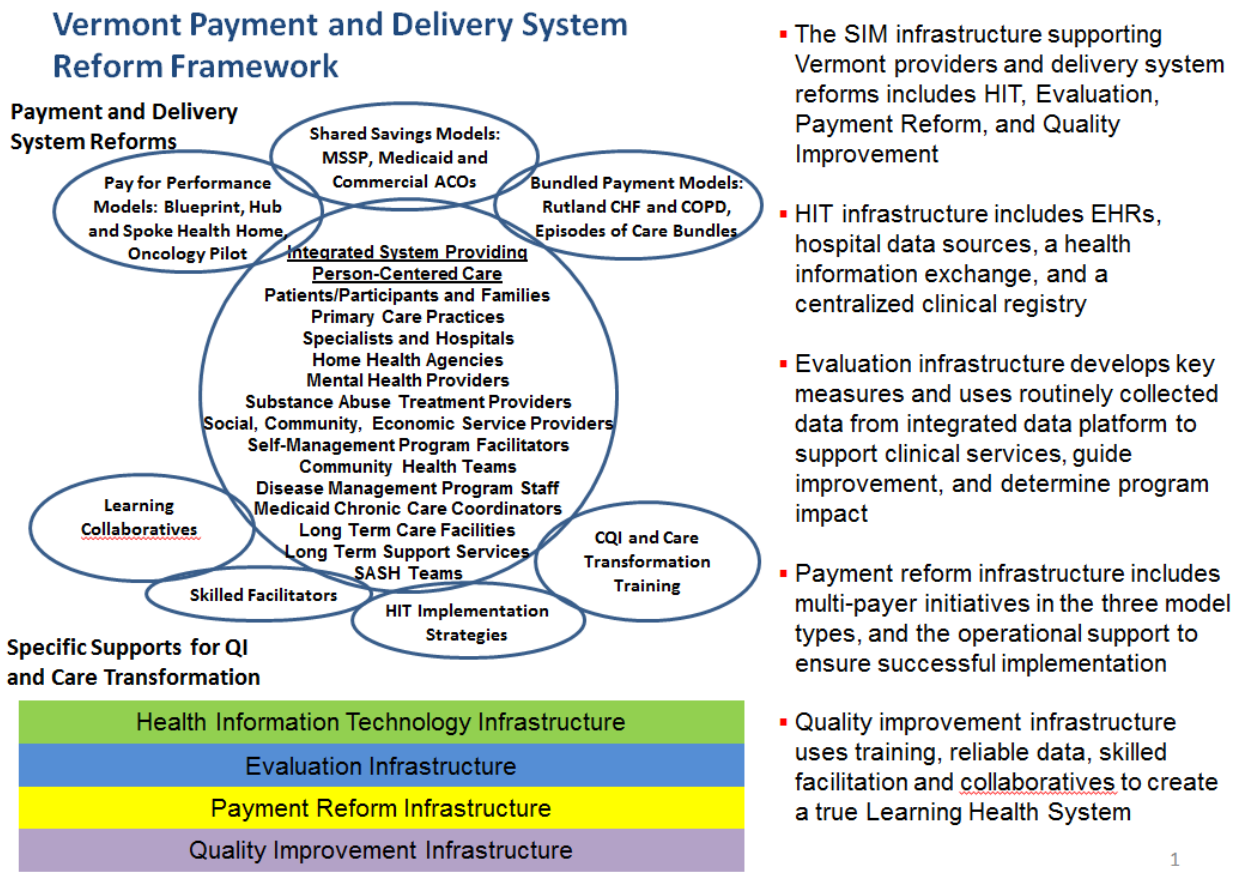
This section discusses Vermont's plans to provide support to providers throughout the transition to alternative payment models. This support will include training on continuous quality improvement.

Question 33. Has Vermont identified quality improvement supports for providers, including training on continuous quality improvement methodology or participation in learning collaboratives?

Question 34. What are the activities related to practice transformation training and care process redesign supports that leverage existing statewide learning and action networks (e.g. PCMH, Health Home, regional extension centers) and other communication vehicles engaging providers?

Vermont strives to create a Learning Health System, where information and experiences are used to continuously improve quality. As new payment and delivery system reforms are implemented, this foundational Learning Health System infrastructure will serve as a mechanism for communicating the objectives and characteristics of the reforms, and will also provide a mechanism for training on care transformation. In addition to supporting providers in clinical and operational care transformation, it will be important to support them in health information technology (HIT) and the use of data and analysis in improving care. HIT and data analysis, including an integrated health record that can be accessed by all providers and improved analytic capability to provide timely and accurate information to clinicians, will be essential elements in care transformation.

The following graphic depicts the relationship between the ideal of a fully-integrated provider system, the specific care transformation and quality improvement supports envisioned by SIM, current and planned payment and delivery system reform initiatives in Vermont, and the foundational infrastructure needed to support this system change:



Vermont has a long history of developing and supporting quality improvement infrastructure for providers; the result is a rich array of learning collaboratives, skilled quality improvement specialists, and improvements in health information technology and data analysis to engage and support providers as they seek to transform the way they deliver services and improve patient care. Examples of these initiatives include the following:

Blueprint for Health

As part of the Blueprint for Health model, the State has recruited and funded a strong network of 13 highly skilled practice facilitators to work with primary care practices that have either already been recognized as patient centered medical homes (PCMHs) or are in the process of becoming recognized. These facilitators assist practices in identifying, refining and documenting processes (including quality improvement processes) that meet NCQA's PCMH

standards. After recognition is achieved, facilitators continue to assist practices in ongoing data-guided quality improvement initiatives. Examples of facilitator-led PDSA quality improvement initiatives are included in the Key Artifacts. To date, Blueprint practice facilitation has been focused on more than 100 primary care practices (out of approximately 180 primary care practices in the state); another 16 practices are currently scheduled for facilitator-led NCQA recognition and quality improvement assistance by the end of 2014, and that number is likely to increase. The program is beginning to branch out to specialists, including substance abuse treatment Health Home "hubs" serving complex opioid dependent patients receiving methadone or buprenorphine, and an OB-GYN practice in Northeastern Vermont.

These practice facilitators, who are state contractors, have formed a Learning Health System; they meet together twice each month to discuss topics of mutual interest, share experiences, and receive training. They also maintain contact through an electronic communication system called Basecamp. The SIM grant will expand the number of contracted facilitators serving Blueprint practices by 3 to 5 FTEs, and will ensure that their training, work and methods reinforce the goals of the SIM payment and delivery system reforms. Each FTE facilitator supports 8 to 10 practices, so the increase could result in facilitation for 25 to 50 additional practices. The expansion in practice facilitation resources will be a critical factor in meeting the needs of providers engaged in the various transformation activities required for SIM success. The specific number and focus of additional facilitators will be determined by a multi-stakeholder Care Management Work Group, which will begin meeting late in the third quarter or early in the fourth quarter of calendar year 2013.

The Blueprint also offers learning collaboratives to participating practices and interested providers on a variety of topics. Current topics include Asthma Care, Cancer Screening, and Medication Assisted Treatment for People with Opioid Dependence. Learning collaboratives consist of in-person meetings, web-ex meetings, training on quality improvement processes, data sharing among participants, and design and testing of interventions. The SIM grant will support six additional learning collaboratives, at the local, regional and state levels. Vermont will work with a contractor and multi-stakeholder work groups to identify the most relevant and appropriate topics, competencies and curricula to be addressed by these new collaboratives. As is the case with current initiatives, these additional collaboratives will include learning forums and comparative performance reporting to guide ongoing quality improvement. The SIM grant will allow for testing and refinement of these collaboratives.

The Blueprint supports additional shared learning forums in Vermont, including Integrated Health Services Workgroups in each of the state's 14 health service areas, regular meetings of Blueprint Project Managers to resolve problems and identify best practices, the Blueprint annual conference that brings together local and national leaders, and the multi-state advanced

primary care collaborative supported by the Milbank Memorial Fund that brings together leaders from states that are engaged in Advanced Primary Care Practice programs.

The Vermont Child Health Improvement Program and the Vermont Program for Quality in Health Care

The State provides funding to the Vermont Child Health Improvement Program (VCHIP) and the Vermont Program for Quality in Health Care (VPQHC), two statewide organizations with a focus on quality improvement.

VPQHC Work

VPQHC was incorporated as a Vermont non-profit corporation in 1988. Founders included representatives of state agencies, physicians, hospitals and insurers. Beginning in 1990, VPQHC's primary activities have centered on providing training and expertise to hospitals in the use of continuous quality improvement (CQI) and developing medical quality improvement projects in specific clinical areas (e.g. - Obstetrics & Gynecology, Cardiology, Orthopedics, and Mental Health).

In 1996, the Vermont Legislature passed a law that required the state to annually contract with VPQHC to: "Implement and maintain a statewide quality assurance system to evaluate and improve the quality of health care services rendered by health care providers or health care facilities, including managed care organizations, to determine that health care services rendered were professionally indicated or were performed in compliance with applicable standards of care, and that the cost of health care rendered was considered reasonable by the providers of professional health services in that area." (18 VSA § 9416)[5]

VPQHC's current projects include:

- Improving transitions of care and reducing avoidable readmissions,
- Preventing healthcare acquired infections (includes hospitals and long term care facilities),
- Improving care for stroke patients and reducing unnecessary CT scans,
- Providing pooled multi-insurer data on selected quality measures to pediatric practices,

[5] Material from VPQHC website at http://www.vpqhc.org

- Supporting end of life medical decisions, and
- Assisting critical access hospitals with periodic evaluations and quality assurance reviews.

VPQHC's history of encouraging collaborative continuous quality improvement has helped to establish a culture of data-driven care transformation among various provider communities in Vermont. The SIM grant allows Vermont to build on the processes and relationships that VPQHC has developed, in order to expand quality improvement and care transformation opportunities.

VCHIP's Work

VCHIP is a population-based child and adolescent health services research and quality improvement program of the University of Vermont. It provides an established mechanism for Vermont's clinicians to continually improve the care they offer children and families. To build a shared vision of quality health care for children and families, VCHIP facilitates cross-functional partnerships including researchers, practitioners, insurers, professional organizations, and government.

VCHIP focuses on providing expertise and support to local clinicians interested in implementing changes in their office systems, state policy leaders looking to make informed decisions, and national organizations seeking system-wide transformation.

Improvement initiatives begin with the critical step of selecting and defining measures that are used to test changes and track progress. Collected dynamically over time, data provide important information about current processes as well as the long-term impact of quality improvement initiatives. Along with solid data, practitioners need the knowledge, tools, and support to change systems and improve the quality of the care they deliver to patients and families. VCHIP researches the latest evidenced-based guidelines to develop educational materials and tools to better inform health care practices and to provide consultation and training on how to integrate best practices into current care delivery systems. To accelerate learning, VCHIP coordinates multi-level discussions where health professionals have the opportunity to learn from one another. Projects include extensive work across Perinatal, Early Childhood, School Age and Adolescence, and Chronic Care initiatives. VCHIP has been called

upon to act as a resource for many national initiatives aimed at enhancing private and public maternal and child health practice.[6]

VCHIP provides practice facilitators for some of the state's pediatric practices; as part of the facilitator Learning Health System, these VCHIP staff members share their quality improvement expertise with their colleagues. The organization has played a key role in PCMH recognition for Blueprint practices, as well as in certain aspects of the evaluation of the Blueprint program.

VCHIP has had much success in fostering an improvement culture with the state's pediatric and family practices. The SIM grant will allow Vermont to leverage that success in the form of expanded quality improvement and care transformation initiatives.

Other state agency and provider-based quality improvement initiatives

Other state agency, provider-led or provider-focused organizations have also served as convening entities for quality improvement initiatives. One such organization is the Vermont Department of Disabilities, Aging and Independent Living (DAIL) and the long term support services provider organizations that deliver services to people who are aging and living with disabilities. Vermont participated in the 2012 CMS Partnership to Improve Dementia Care in Nursing Facilities and reduce inappropriate use of antipsychotic medications by 15% by the end of 2012. Working through the Local Area Networks for Excellence (LANE) – which have 100% voluntary participation – DAIL is implementing the nationally recognized OASIS training and funding for consultation. DAIL has additional quality improvement and care transformation initiatives; brief descriptions of those are found in the Key Artifact entitled DAIL Quality Improvement and Care Transformation Initiatives.

The Vermont Department of Health (VDH) collects data on a variety of population health measures for surveillance and evaluation purposes, and has led quality improvement initiatives, including a notable effort in conjunction with VPQHC and providers to reduce healthcare-acquired infections in hospitals and long term care facilities.

Quality improvement initiatives and sharing of best practices are also spearheaded by provider organizations, such as the Vermont Association of Hospitals and Health Systems, the Vermont Assembly of Home Health Agencies, the ACOs, Bi-State Primary Care Association (which

[6] Material from VCHIP website at http://www.uvm.edu/medicine/vchip

represents FQHCs and other safety net providers), the Vermont Health Care Association (representing long term care facilities), the Vermont Psychological Association, the Vermont Psychiatric Association, the Vermont Medical Society, the Vermont Council of Developmental and Mental Health Services, Area Agencies on Aging, and physician specialty organizations (such as the Vermont Chapters of the American Academy of Pediatrics and the American College of Surgeons). Two examples of provider initiatives include the VDH project to reduce healthcare acquired infections (involving the Vermont Association of Hospitals and Health Systems and the Vermont Health Care Association), and a project to reduce surgical complications recently proposed by the Vermont Chapter of the American College of Surgeons.

These initiatives generally involve collaboration between providers, across provider types, with state agencies, and/or with statewide organizations. Provider-led initiatives can be particularly effective because of the degree of provider engagement that they are able to achieve. An example of a provider-led initiative with a high level of engagement is the proposal to participate in the American College of Surgeons National Surgical Quality Improvement Program. The proposal has been brought forth by general surgeons from each of Vermont's thirteen hospitals that provide surgical services. The SIM grant will help provide a framework and supportive infrastructure for these important efforts.

Using Managed Care Regulation to Drive Quality Improvement

Vermont has used statutory authority found in 18 VSA § 9414 to embed extensive quality improvement requirements into its managed care regulation, Rule H-2009-03. Managed care organizations (MCOs) are required to collect and share data with high-volume providers, benchmark such providers against quality standards, support them in improving quality, and develop multi-MCO quality improvement initiatives. An example of a multi-MCO-initiated quality improvement initiative is the Vermont Youth Health Improvement Initiative, led by VCHIP.

Despite these multi-insurer initiatives, much of the quality improvement activity undertaken by health insurers through their MCOs is conducted on an individual MCO basis. The SIM grant will help coordinate these efforts, by improving the development of multi-payer data sources, identifying key measures for targeted improvement, providing resources to assist in quality improvement and care transformation, and supporting multi-payer quality initiatives.

Using Improvements in Health Information Technology (HIT) to Drive Quality Improvement

Vermont's strategy for improving health information technology is articulated in the state's Health Care Innovation Plan. Implementation strategies include creating a statewide health information network that connects the full spectrum of providers and consumers, creating statewide master persons and master provider directories, and integrating data from various sources on a common platform(s) to support robust measurement and analytics for the Learning Health System. These strategies, along with Vermont's efforts to continuously improve data mapping and normalization at the practice level, are critical to providing real-time data to support quality improvement. The SIM grant will be used to develop an integrated data platform(s), enhance data mapping and normalization, ensure secure transmission networks, and enhance data management and quality assurance within the integrated data platform(s).

Vermont's Regional Extension Center (REC) team is housed at Vermont Information Technology Leaders. VITL's "eHealth Team" of skilled information technology outreach staff is refining its focus to address identified clinical and business data quality issues to meet the state's data quality objectives. Assistance includes providing data quality education to practices, including webinars, FAQ reference documents and data readiness assessments; and training practices on EHR usage and data collection to support the state's clinical and business quality data measures.

The SIM grant will help to ensure that the full range of Vermont's existing and planned care transformation and quality improvement supports (including training, learning collaboratives, on-site practice facilitation, and HIT improvements) are available to support the state's provider communities and innovative health delivery system reforms. While these supports have been widely available to a variety of programs and provider groups, these efforts will be coordinated, expanded and enhanced during the SIM testing period. The following table describes the integration of supports with different delivery system reforms and provider communities:

Delivery System Reform or Provider Community	Summary of Reform	Status of Integration of QI/Care Transformation Support
Vermont Blueprint for Health Advanced Primary Care Practices	Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project, including 113 of the state's primary care practices that are currently recognized as PCMHs (approximately 2/3 of the total primary care practices in the state)	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports.
Vermont Blueprint for Health Community Health Teams (CHTs)	There is a CHT in each of the state's 14 health service areas; they are part of the MAPCP demo. They are locally-designed, and include staff members such as care coordinators, social workers, mental health counselors, dieticians and health coaches. They offer individual care coordination, population management and outreach, and close integration with other social and economic support services. The goal is to provide patients and their families with seamless integration of person-centered care across the continuum of health, social, economic and community services.	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports.
Blueprint Integrated Health Services (IHS) Workgroups	IHS Workgroups in each health service area identify gaps in care and plan the structure and staffing of CHTs. These Workgroups include representatives of community, economic and social service organizations (e.g. – community action agencies, housing organizations, area agencies on aging, educational organizations, transportation agencies) in addition to health care providers.	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports. Vermont is considering offering CQI training to IHS Workgroups.
Vermont's Health Home initiative for people experiencing opioid dependence ("Hub	This program provides registered nurse and mental health clinician support to augment the services of centers ("Hubs") and community physicians ("Spokes") who are prescribing methadone and buprenorphine to this population of patients. Vermont is	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports.

and Spoke")	planning to expand the health home concept to Vermont residents in need of mental health services and long term support services, which will result in further integration of care and services.	
Coalitions of hospitals, physicians and other service providers	Various provider communities participate in quality improvement projects facilitated by VPQHC, VCHIP and other coordinating entities.	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports.
Medicaid's Vermont Chronic Care Initiative (VCCI)	The VCCI program deploys care coordinators in local communities to assist high-risk Medicaid beneficiaries.	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports.
Support and Services at Home (SASH)	SASH is a partnership led by housing providers that connects affordable housing with health and long term services, providing targeted support and services to help high-risk Medicare beneficiaries remain safely at home. It is part of the MAPCP demo. SASH sites are located in housing hubs throughout the state. Each site has a SASH Coordinator and a wellness nurse who work with a care coordination team consisting of staff from home health agencies, mental health agencies, area agencies on aging and other organizations to improve care coordination, care transitions, health promotion, and disease prevention.	Facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports.
Practices, facilities and other providers developing electronic health	Development of a statewide health information network that connects providers and consumers, creates statewide master persons and master provider directories, integrates data from various sources on a	Facilitators and HIT improvement strategies are in place; Vermont Information Technology Leaders [VITL] outreach

record (EHR) and other HIT capability to drive care transformation and quality improvement	common platform(s) to support measurement and analytics, ensures secure transmission networks, and continuously improves data mapping and normalization at the practice level to support patient care and quality improvement.	staff are working directly with providers to establish interfaces between their EHRs and the state's Health Information Exchange, and with practice staff, Blueprint staff and facilitators to ensure that the data available to clinicians is timely, accurate, and reliable.

Operational Plan

The following activities will occur to ensure implementation of quality improvement and care transformation training and supports across a wide array of providers. The following information is also summarized in a table below.

- Approach Blueprint about providing CQI training to Integrated Health Services Workgroups, identify CQI training approach and materials, provide IHS work groups with access to training (8-1-2013 through 12-31-2013; responsible parties include GMCB Payment and Delivery System Reform [PDSR] Team, Blueprint staff and project managers, IHS Workgroups). Target providers include community, economic, social and long term support services providers; recruitment strategy includes membership on IHS; strategy for participation includes ready access to no-cost training.

- Determine where and for what initiatives additional facilitator resources are needed, recruit and hire facilitators, deploy into settings or initiatives where needed (8-1-2013 through 12-31-2013; responsible parties include DVHA, Blueprint staff, GMCB PDSR Team). Target providers include specialists and other non-primary care providers; recruitment strategy includes provision of no-cost facilitation resources; strategy for participation includes assistance with provider recognition processes (e.g. – NCQA Specialist Recognition) and quality improvement that could lead to better patient care and enhanced payments.

- Identify providers in need of additional care transformation training, identify training approach and materials (including information about Vermont's specific care transformation initiatives), provide access to training (8-1-2013 through 3-31-2014; responsible parties include GMCB PDSR Team, Blueprint staff and project managers, provider organizations). Target providers include any providers in need of care transformation training; recruitment strategy includes dissemination of information on training opportunities through provider organizations; strategy for participation includes ready access to no-cost training.

OPERATIONAL PLAN – Quality Improvement & Care Transformation

Goal	Action Steps	Targeted Stake-holders	Provider Recruitment Strategy	Strategy for Stakeholder Participation	Start Date	End Date	Responsible Parties	Milestone
Provide quality improvement and care transformation support to a variety of stakeholders	Approach Blueprint about providing CQI training to IHS Workgroups; identify CQI training approach and materials; provide IHS work groups with access to training; identify post-training CQI resources for participants	Community economic, social and long term support services providers	Participation in IHS Work Groups	Ready access to no-cost training Participation will be tracked by attendance lists at each training; participants will be surveyed several months after the training to see if it has impacted CQI efforts in their organizations	8-1-13	12-31-13; Ongoing	Blueprint: C Jones L Watkins Project Mgrs IHS WGs GMCB: PDSR Team	All 14 IHS Work Groups are offered CQI training and accept and implement such training
	Determine where and for what initiatives additional facilitator resources are needed, recruit and hire facilitators,	Primary care providers without facilitators; specialists and other non-primary care providers	Provision of no-cost facilitation resources	Assistance with provider recognition processes (e.g. – NCQA Specialist Recognition) and quality improvement that could lead to	8-1-13	12-31-13; Ongoing	Blueprint staff, GMCB PDSR, SIM Work Groups	All practices that want facilitation have access to such resources

	deploy into settings or initiatives where needed			better patient care and enhanced payments. Participation will be tracked as number of practices with facilitation; facilitators will report on practice recognition, quality improvement projects, and other aspects of transformation				
	Identify providers in need of additional care transformation training, identify training approach and materials (including information about Vermont's	Providers in need of care transformat-ion training	Dissemination of information on training opportunities through provider organizations	Ready access to no-cost training Participation will be tracked by attendance lists at each training; provider organization membership will be surveyed to determine their knowledge of	8-1-13	3-31-14; Ongoing	GMCB PDSR Team, Blueprint staff and project managers, provider organizations	All providers that want such training have access to it; providers have working knowledge of Vermont's transformati on initiatives

	specific care transformation initiatives), provide access to training			Vermont transformation initiatives and need for additional training				

Key Artifacts:

Exhibit	Artifact	URL
	Vermont Blueprint for Health	
54	Blueprint for Health 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
48	Blueprint Facilitator Grant Agreement Language	
45	**Blueprint 2013 Meeting Dates**	
	All Meetings	
	CHT	
	Payment	
	Project Managers	
	Facilitators	
	Self-Management	
	MAT Collaborative NW	
	MAT Collaborative SW	
	Asthma Collaborative	
	Cancer Collaborative	
70	**Facilitator-led PDSA summaries**	
	PDSA Blank Worksheet	
	Health Center in Northeastern Vermont	
	Northern Vermont Practice: Tobacco	
	Northern Vermont Practice: Diabetes	
	Vermont Practice: Hypertension	
50	Blueprint Facilitator Training Calendar	
49	**Blueprint Facilitator Meeting Notes**	
	Facilitator Meeting Notes 1/28/13	
	Facilitator Meeting Notes 2/11/13	
	Facilitator Meeting Notes 3/4/13	
	Facilitator Meeting Notes 4/1/13	
47	**Blueprint Facilitator Basecamp threads**	
	Full List of Threads (password protected)	
	Asthma	
	Medications	
45	Blueprint 2013 Meeting Dates (Learning Collaboratives and others)	

59	Blueprint participating practices and entities (list)	
190	VPQHC continuous quality improvement initiatives	
	VCHIP Artifacts	
148	VCHIP quality improvement initiatives	http://www.uvm.edu/medicine/vchip/documents/2011VCHIPINSERT_QI.pdf
57	Blueprint Integrated Health Workshop Participants	
147	VCHIP Evaluation of Blueprint Adoption	http://hcr.vermont.gov/sites/hcr/files/Blueprint_QualitativeEval_VCHIP_July15_2011.pdf
	Statutes and Regulations	
130	Rule H 2009-03 (Part 6)	http://www.dfr.vermont.gov/sites/default/files/REG-H-09-03.pdf
17	18 V.S.A. § 9414	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09414
18	18 V.S.A. § 9416	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09416
	Additional Artifacts	
132	SASH sites and organizations	
177	VITL Outreach Staff	
149	VDH Health Care Acquired Infection Project Report	http://healthvermont.gov/prevent/HAI/documents/VTMDROCOLLABORATIVEFinalReport33112.pdf
66	DAIL Quality Improvement Examples	
107	Medicaid Vermont Chronic Care Initiative (VCCI) Staff	
	Blueprint Learning Collaboratives	
	Asthma Collaborative Materials	

41		Asthma Learning Collaborative Proposed Processes for Planning and Implementation
39		Asthma Collaborative Planning Team Meeting Notes - 2/15/2013
40		Asthma Learning Collaborative Presentation
	Cancer (Preventive Services) Collaborative Materials	
62	Cancer Burden Presentation	
63	**Cancer Screening Collaborative May 3, 2013 Meeting Materials**	
		Meeting Agenda - 5/3/2013
		Cervical Cancer Guidelines Presentation (Wegner)
		Best Practices for Increasing Screening Rates Presentation (Mallory)
		Cancer Screening Measures
		Vermont Department of Health Cancer Screening Guidelines
		Chart Audit Tool
		Chart Audit Instructions
		Chart Audit Data Data Collection and Display
		Session Evaluation
	Medication Assisted Treatment (MAT) Collaborative Materials	
102		MAT Collaborative Executive Summary
103		MAT Collaborative Evaluation

Section N	Sustainability Plans

This section addresses Vermont's plans for sustaining the new payment and delivery system models after the SIM grant program ends. Vermont will use SIM funding to transform the health care payment and delivery system. Any SIM initiatives that continue past the SIM funding period will be funded through savings in health care costs achieved by successful models.

Question 35: Has the State developed an evidence-based financial model for sustaining new payment and service delivery model(s) after the testing phase is complete, based on leveraging a comprehensive set of funding sources?

a. How is the program being structured to make it sustainable in the absence of SIM funds?

b. Has the state developed an evidence-based financial model to be put in place at the conclusion of the grant period?

c. Is the state looking at a comprehensive package of federal sources for beyond the SIM grant (ie. MMIS, other state and federal)?

Vermont's SIM Project is part of the state's health reform efforts. As described in Sections A and B of this Operational Plan, Vermont embarked on a bold set of reforms with the passage of Act 48 of the Acts of 2011. These reforms charge the Executive Branch and the Green Mountain Care Board with creating a high-performing health system that provides Vermonters with the highest quality of care at a sustainable cost. These reforms require that we use our regulatory and policy levers, as described in Section G of this Operational Plan, to develop evidence-based financial models for health system financing.

The Green Mountain Care Board (GMCB) is responsible for measuring health care costs and their annual growth in an evidence-based manner. This is accomplished through two major GMCB efforts, the retrospective Expenditure Analysis and the prospective expenditure forecast. Under the GMCB's authority, these two efforts have been reframed to make them more robust and transparent. These tools provide the core of the evidence-based financial model that will

be used during the SIM Project and after its conclusion. Vermont anticipates the need for additional financial modeling during the project to ensure these two tools are optimized.

Ongoing Funding Needs

Vermont's SIM implementation plan, as described in the SIM Timeline, is to phase in models over the SIM Model Testing period. The phased approach requires contract and staff resources to perform existing payment and delivery system tasks, while simultaneously innovating. The State of Vermont's SIM budget includes funding for a combination of personnel and contracts to support transformations in the payment and delivery system. Vermont has structured its SIM funding to provide infrastructure and capacity for the transition from existing payment and delivery systems to alternate payment and delivery systems.

Vermont will use SIM funding to support the development of tools and new models, while at the same time maintaining existing structures until they are no longer needed. As new payment mechanisms come online, we will no longer need staff and contracts to perform current tasks and will train those staff for their new roles. Vermont is intentionally seeking contract services to provide much of this transitional support as those contractors will provide subject matter and technical expertise and also enable us to use one-time funding more efficiently. The State will also become more efficient in its role as payer and regulator.

The State of Vermont will use the funding to support the transition from the current payment and delivery system to alternative payment and delivery models. The models should be successful in producing savings and increasing quality. Vermont will sustain any personnel and tasks using model savings and through re-deployment of vacant positions in state government that may be no longer needed given new models of provider oversight and financing.

Vermont has determined that we will need ongoing support for a few of the personnel identified in the grant and three classes of contracts: data and infrastructure, ongoing evaluation and monitoring and the learning health system. We provide more detail on these below.

Personnel

Vermont expects to retain a small fraction of the staff hired under the SIM grant after the SIM/Duals Project ends. The SIM grant provides support for.25 FTE each for the two Directors of Payment Reform. Vermont will provide ongoing support for these staff through state budget appropriations subsequent to the grant period's conclusion. Of the remaining 22 positions, all

are defined as limited service and any staff will be retained through re-deployment/retraining of existing state staff.

Contracts

Ongoing data and infrastructure needs

The State of Vermont is using SIM funds to develop a large portion of our data infrastructure. Specifically, we are doing the following:

- Building connections between providers and the state's data sources;
- Connecting more providers to our Health Information Exchange (HIE);
- Enhancing the clinical registry;
- Integrating the state's clinical registry and claims data reporting systems.

The funds provided through SIM are in addition to other funding the state has received through our health information technology claims assessment, Medicaid and HITECH. Vermont is aware of the complexity of federal IT funds available and, as described in Section A, is tasking the SIM Government Operations Team to ensure all activities in this area are aligned.

The SIM funding allows Vermont to build the infrastructure necessary to support new payment models and educate providers on the new data systems. Once Vermont has developed the electronic connections, we will need to maintain those connections and improve them as new technologies emerge. As a data system, it also needs significant ongoing maintenance for upgrades. We anticipate that the remaining existing sources of funding will be sufficient to support the ongoing maintenance for the data systems described in the SIM grant proposal.

Learning Health System needs

Shifting to alternative payment systems requires collaboration among providers, payers and government. It also requires a willingness to continually learn and build towards a high performing health system. The State of Vermont will pull all of these entities together throughout the grant period to encourage discussion and shared learnings as part of a learning health system. Vermont will continue to support its learning health system after SIM funds are expended. The learning health system includes practice facilitators and learning collaboratives. The learning health system fosters delivery system transformation and supports the clinicians providing care to Vermonters. Vermont is committed to continued quality improvement efforts, and, as described in Sections I and M, has a strong track record of this work. These initiatives will be funded through existing learning health system mechanisms, like those currently in use by the Blueprint for Health, and model savings.

Evaluation and system monitoring

The State is committed to evaluating which SIM initiatives and models work and expanding those deemed successful. The State will also use evaluation to improve initiatives and eliminate those that are not success at improving health and lowering cost. The State will perform independent evaluation and internal evaluation in the SIM Project because we are testing new payment and delivery mechanisms. With SIM, we need to ensure that health is improving and costs are constrained. Assuming that we have success with the models tested, Vermont will need to maintain those successful models. The intrinsic nature of a testing period requires intense evaluation to ensure the project's goals are being met. Once the testing period is over, we will resume the standard evaluation and monitoring protocol in place in the state. In order to do this, Vermont will do a less intense, but ongoing evaluation and monitoring of the system built off of the existing surveys and evaluation. The State currently engages in high-level monitoring of the health care system through several mechanisms including, but not limited to:

- *The Household Health Insurance Survey.* This biennial survey measures access to health care services.
- *The Behavioral Risk Factor Surveillance Survey*. This annual survey measures the health of Vermont's population.
- *Funding for Health Utilization Analyses.* The GMCB has a contract with Truven Health Analytics to provide health system utilization analyses.

Vermont expects these would be sufficient to properly monitor and evaluate Vermont's health care system once the SIM Project is completed.

Federal funding beyond the SIM grant

Vermont continues to work with its federal partners to identify opportunities for funding to support federal and state health system goals. As described in Section B of this Operational Plan, Vermont is committed to creating a health system that is of high quality and sustainable in the long term. Vermont will engage all payers, including Medicare, using program outcome data to engage participating payers in discussion about whether ongoing participation is a good investment in any of Vermont's payment and delivery system initiatives.

Key artifacts:

Exhibit	Artifact	URL
91	Health Care Expenditure Analysis (2010)	http://gmcboard.vermont.gov/sites/gmcboard/files/2010EA040212.pdf
92	Health Care Expenditure Analysis (2011)	http://gmcboard.vermont.gov/sites/gmcboard/files/2011_Expenditure_Analysis_42313.pdf

Section O Administrative Systems and Reporting

This section describes Vermont's programmatic and financial oversight of SIM cooperative agreements. Overall oversight will be performed by the SIM Project Director under the general guidance of the SIM Core Team.

Question 36. Has the state identified and activated an office/entity responsible for the programmatic and financial oversight of cooperative agreements?

Vermont has assigned the SIM Project Director to oversee administration of the SIM project, including management of the budget and financial reporting. Vermont's Agency of Human Services is the official fiscal recipient of SIM Funding according to the Notice of Award. The Project Director will work with AHS to develop Memoranda of Understanding with the Agency of Administration and the Green Mountain Care Board for the areas over which those agencies have oversight. Within the Agency of Human Services, funds for personnel and contracts will be transferred to the Department of Vermont Health Access and the Department of Aging and Independent Living.

The Project Director will work with the Government Operations Team, described in Section A, to ensure all reporting is in compliance with federal and state requirements. As indicated in Section A, the Project Director has not yet been hired. Vermont's SIM leadership team has assigned two Government Operations Team members, Georgia Maheras and Kate Jones, to lead this effort until the Project Director is hired.

The Government Operations Team is comprised of individuals across multiple state agencies with expertise in managing financial data and budgeting. These individuals are familiar with federal reporting requirements as they currently provide reporting to the federal government for the health benefit marketplace grants, rate review grants, Blueprint MAPCP program, and other federal grants received by Vermont. Additionally, the members of the Government Operations team are experts in state procurement rules, including assuring deliverables and

compliance for federally-funded sub-contracts. The Government Operations Team is also experienced in coordinating state funding, funding through the Global Commitment Waiver, the Choices for Care Waiver and private foundation grants.

The Project Director, along with the Government Operations Team will ensure that all of the state agencies involved in the project are programmatically and fiscally responsible. Each agency receiving SIM funding will have a representative on the Government Operations Team to ensure fiscal integrity. This team will review federal reporting requirements and ensure funds allocated to SIM are in compliance with all SIM terms and conditions and that SIM funds are coordinated with any other relevant federal funding including, but not limited to: Medicaid funds, VHC funds, Duals funds and IAPD funds. The State of Vermont complies with federal auditing rules for all federal funding. The audit procedure is described in Bulletin 5.0, which can be found in the Artifacts for Section O.

At this time, we do not anticipate the need for additional fiscal policies related to SIM funding, but should the Government Operations Team determine additional forms and policies are necessary for appropriate fiscal operation of the SIM Project, they will develop these policies and present them to the Core Team for approval.

Key Artifacts:

Exhibit	Artifact	URL
152	Vermont Agency of Administration Bulletin 5: Single Audit Policy for Subgrants	http://aoa.vermont.gov/sites/aoa/files/pdf/AOA-Bulletin_5.pdf
151	Vermont Agency of Administration Bulletin 3.5: Contracting Procedures	http://aoa.vermont.gov/sites/aoa/files/pdf/AOA-Bulletin_3_5.pdf
74	GMCB - DVHA SIM Grant MOU	

Section P	Implementation Timeline for Achieving Participation and Metrics

This section describes Vermont's plans for completing the "model testing" proposed in our grant application – plans for implementation of payment models that are alternatives to fee-for-service and related health system innovations, including timelines for implementation and metrics for gauging progress.

Question 37. Has the State developed a project plan for completing Model Testing and implementing the proposed innovation model that is actionable by the project team (with assignments of responsibility) and provides detailed project tracking and reporting by the project oversight entity and CMS

The State has developed a project plan for testing and implementation of three payment models through 2016. The payment models to be tested include Pay for Performance (P4P), Episodes of Care (Bundled Payments) and the Shared Savings Program Accountable Care Organization (SSP-ACO) Model. Additionally, alignment of care delivery models under development in Medicaid has also been identified as integral to the success of one of the goals of the SIM project. The testing models are described below. Each of these models will be coordinated with ongoing implementation and evaluation of the Blueprint for Health, the State's Advanced Primary Care Medical Home demonstration and the Financial Alignment Demonstration (the "duals demo"). The general development of these models, for both Medicaid and commercial insurer application, is described below. More detailed plans and timelines are provided in attachments to this plan.

1. Pay-for-Performance Payment Model

As described in the SIM grant proposal, Vermont intends to approach payment reform at three different levels to maximize and accelerate reform of the overall system. In addition to population-based on collaborative model approaches described above, individual provider pay-for-performance models will also be developed. Moreover, the Vermont Legislature recently passed a bill supporting annual state fiscal year Medicaid rate updates--approximately 3%--intended to 1) start to close the cost shift between private and public payers and 2) be linked to

value. Starting in SFY15, Medicaid plans to use the new annual funds to create a quality pool to fund the P4P programs created.

The development of the Medicaid P4P models will leverage the SIM Payment Models Work Group (a reconstitution of the ACO standards work group) and Steering Committee to garner public-private input on Medicaid's P4P programs. To the extent possible, Medicaid will leverage existing or already planned value-based initiatives like the Blueprint for Health Advanced Primary Care Practice framework, which makes payments based on NCQA PCMH level achieved. Another example is Medicaid's development of a hospital avoidable readmissions program, which is based on Medicare's approach. As others are developed and adopted, VT Medicaid will seek to build on approaches in use by Medicare and commercial payers to the extent possible to both reduce administrative burden on providers as well as make the initiatives more meaningful by aligning incentives across payers. Medicaid is also leveraging commercial approaches; MVP for example, is actively sharing its performance measures to Medicaid and Medicaid is using components of the BCBS Alternative Quality Contract in its P4P design and strategies.

As illustrated in the P4P timeline in the appendix, Medicaid plans to hire some contracting resources to assist with the development of its P4P plan in late 2013 followed by discussions of the P4P models within the Work Groups and Steering Committee to occur in the first quarter of 2014. Additional targeted stakeholder meetings would be held in the second quarter of 2014 along with the release of a Medicaid "Value-based Purchasing Plan."

Similar to the approach used for the other models, Medicaid expects to submit a concept paper to CMCS in order to facilitate the SPA process upon implementation in third quarter. The launch date of the program would coincide with the SFY, with quality payments being made retrospectively starting in Q1 2015. Medicaid will continue the cycle of evaluation and expansion following launch and in preparation for SFY16 P4P program.

Commercial Pay-for-Performance Model Development and Implementation

We have no explicit plans for implementation of new commercial pay-for-performance models at this time. As mentioned above, commercial payers have some such programs in place already. In addition, all payers continue to pay enhanced payments to Blueprint advanced primary care practices under the state's multi-payer demonstration program. The models developed for the Medicaid P4P program might very well prove usable by commercial payers. The work group process for vetting the P4P design will include representatives of commercial carriers.

2. Episodes of Care Payment Model

There is growing evidence that the quality of care of some acute and chronic conditions can be greatly improved by developing a collaborative Episodes of Care (EOC) or "Bundled Payments" program. By providing a forum and data analytics, identifying an “accountable provider(s)” and including financial incentives, providers will have the tools to come together to transform care for certain EOCs thereby increasing quality and reducing variation in cost. After providers improve care and achieve efficiencies, payers may choose to implement a bundled payment for these episodes, which introduces downside risk in addition to rewarding good performance. Vermont will leverage the work done in Arkansas and adapt it for the Vermont context under its State Innovation Model (SIM).

The SIM Payment Models Work Group will provide key input and make actionable recommendations on the details of the EOC program. Beginning in October the Work Group will provide guidance on the following key elements of the program:

- Criteria for Selecting Episodes
    - Evidence: Only those initiatives where there is evidence that a bundled payment approach results in reduced costs and improved outcomes should be considered. Operationally Feasible: Only those initiatives which are deemed to be operationally feasible for both payers and providers should be pursued.
    - Return on Investment (ROI): Bundled payment pilots should represent substantial opportunities to both reduce costs and improve quality.
- Input on Definition of Episode
- Quality Metrics Associated with EOC
- Method and Timing of Incentive Awards (If any are proposed)
- Criteria for Defining when to Transition to a EOC Arrangement

The goal of the Work Group will be to develop a consistent approach, have statewide support, and present opportunities for expansion to multiple sites. The Work Group will develop recommendations for both commercial and Medicaid EOCs. Vermont would expect that EOC initiatives would be considered throughout the 3 year SIM testing phase, and that a structured approach to considering specific EOCs will be developed by the Work Group with recommendations to the GMCB and the SIM Steering Committee for review and approval.

The Work Group will begin discussions of the EOCs in October, 2013 and will recommend the implementation of at least three or more EOCs on a broad state-wide basis by October 1, 2014. This implementation could occur in conjunction with another payment model such as an accountable care organization (ACO).

In preparation for implementation of EOCs, the state will be contracting with a Learning Collaborative Leader to prepare for, and facilitate the learning collaborative meetings, and an analytics contractor to collect expenditure data, clinical information, and the results of performance measures on each of the payment models we are testing as part of our planned operational evaluation. Also as described in the timeline, Medicaid also plans to hire a contractor to help support the operational and program design elements of the Medicaid specific EOCs early in 2014. The timeline for the collection of this information, preparation of quarterly and annual reports is also incorporated into our timeline.

As part of our Learning Health System, we will be implementing this EOC model in October 2014, and then continuously evaluating performance, considering changes, modifications, and expansions, throughout the SIM Grant period and beyond. All of this work will be coordinated through the ongoing efforts of the SIM Payment Models Work Group.

3. Shared Savings Accountable Care Organization Model

Vermont has proposed testing a Shared Savings ACO with commercial payers and Medicaid. Vermont providers already have organized ACOs to respond to the Medicare SSP-ACO program, and our testing will utilize those organizations that are willing, as well as any others that form and meet our programmatic guidelines, for an expansion to other payers.

In January 2013, OneCare Vermont was awarded status as a Medicare SSP-ACO in Vermont. OneCare Vermont is, to the best of our knowledge, the only statewide ACO recognized by CMS. This ACO was formed by two Academic Medical Centers, Fletcher Allen Health Care (FAHC) in Vermont, and Dartmouth Hitchcock (DH) in New Hampshire. DH provides services to about 30% of Vermont residents using hospital care. All of the employed physicians in both organizations are part of the OneCare ACO. In addition to FAHC and DH, all of the thirteen other hospitals in Vermont, including their employed physicians, have also agreed to participate in this ACO. (This includes eight Critical Access Hospitals and five PPS hospitals). Additional participants include five Rural Health Centers, two FQHCs, the State's only private psychiatric hospital, and fifty-eight provider practices. In total, OneCare includes about 2000 physicians. Total Medicare attributed lives to OneCare are expected to number at least 40,000.

The second approved Medicare SSP-ACO in Vermont is the Accountable Care Coalition of the Green Mountains (ACCGM). This ACO is an IPA model consisting of eight primary care and specialty practices located primarily in Northwest Vermont. The number of Medicare attributed lives to ACCGM is about 6,000.

These two ACOs are currently Medicare-only with start dates of January 1, 2013 and July 1, 2012, respectively. Our financial estimates on the Medicare attribution show growth in the Medicare population and participation over the duration of the SIM period.

In June 2013, the Green Mountain Care Board received an application from six (6) FQHC's in Vermont who have expressed their intent to form an ACO as well. They have filed a Letter of Intent to apply to become a Medicare SSP/ACO (Track 1), and intend to participate in the both the Commercial SSP-ACO and the Medicaid SSP-ACO programs planned under this project.

The State has worked through the ACO Standards Work Group (the Work Group) to define the parameters of a Commercial ACO/SSP program and a Medicaid ACO/SSP program, both with planned start dates of January 1, 2014. The Work Group was convened to develop standards that will help ensure that Vermont's ACOs improve health care quality, patient experience of care and population health; reduce costs across the health care system; and maintain the financial viability of the state's health care system.

The focus of the group has been to develop standards for what it takes to be an "approved" ACO in Vermont in the commercial market and for Medicaid.

The Work Group includes representatives from the State of Vermont, payers, providers, and associations (Hospital Assoc., Medical Society, Home Health, FQHCs, Mental Health). This group has been meeting two times per month since December, 2012 with staffing from the Green Mountain Care Board and consulting support from Bailit Health. It has been co-chaired by Richard Slusky, Director of Payment and Delivery System Reform for the GMCB, and Kara Suter, Director of Payment Reform for the Department of Vermont Health Access (the State's Medicaid Department). The Work Group will be reconstituted under the SIM grant to include broader participation (including providers of long-term services and supports) and to develop recommendations regarding the design and implementation of the Episode of Care and Pay-for-Performance Models envisioned as part of this project. The Work Group's recommendations to date and plans for further work to design and implement the Commercial and Medicaid ACOs are described below.

Commercial ACO Model Development and Implementation

Design of the Commercial SSP-ACO has been the primary focus of the ACO Standards Work Group to date. The recommendations of the Work Group were presented to the SIM Steering

Committee on July 18 and are open to comment from Steering Committee members until July 25. The Work Group will continue to develop the design during August, and incorporate feedback from the Steering Committee, with a plan to present final recommendations to both the SIM Steering Committee and the GMCB in September. SSP-ACOs will be asked to express their interest in participating in the Commercial SSP-ACO program by the end of October and will execute contracts with payers in accordance with the state's guidelines by January 1, 2014. The Work Group has recommended that the Commercial SSP-ACO program be designed around Vermont Health Connect, which will be a unified marketplace for all small group and individual insurance coverage in Vermont, also beginning January 1, 2014.

In addition, the Work Group has made recommendations regarding most elements of the model design, including standards for:

- ACO structure, including financial stability, primary care capacity and patient freedom of choice
- ACO payment methodology, including attribution, covered services, calculation of financial performance and risk adjustment
- ACO management, including alignment of provider payment with the ACO model and distribution of savings

The Work Group has referred two other issues – alignment of care management programs and data use standards – to other SIM work groups.

The detailed recommendations of the Work Group can be found in the appendix.

The approved standards will become the basis for implementation of the program through commercial carriers, evaluation of the program under the SIM grant and oversight of the program through the GMCB.

The appendix provides a detailed timeline and staffing plan for further design and implementation of the commercial SSP-ACO.

Development and Implementation

Implementation of the Medicaid SSP-ACO also is planned for January 1, 2014. Detailed design of the Medicaid SSP-ACO will be a major focus of the Payment Models Work Group for the remainder of this year. The Department of Vermont Health Access (DVHA) is in the process of drafting standards for the Work Group's consideration in early August. The standards will

largely mirror the Medicare and/or Commercial ACO model. Some deviation will be necessary due to the unique needs or characteristics of Medicaid beneficiaries. DVHA and GMCB plan to continue participation in a Commonwealth Fund sponsored "Medicaid ACO Learning Collaborative" along with six other states.

The Work Group recommendations will be presented to the SIM Steering Committee in late August or early September. The approved standards will become the basis for implementation of the program through the DVHA and evaluation of the program under the SIM grant.

At the same time, DVHA and the GMCB have commissioned a concept paper that will outline the parameters of the Medicaid SSP-ACO to facilitate the State Plan Amendment (SPA) process with the Center for Medicaid and CHIP Services (CMCS). DVHA anticipates submitting the concept paper for the SSP-ACO to CMS in early September.

The release of a request for proposals (RFP) to potential ACOs is planned for September. DVHA would finalize contracts with ACOs in November and December, and submit any necessary SPAs to CMCS at that time.

The appendix provides a detailed timeline and staffing plan for further design and implementation of the Medicaid ACO/SSP.

Question 38. Are project activities specified/planned/structured appropriately in terms of sequencing and conducting activities in parallel to achieve results?

Actionable project plans have been developed for each of the models proposed in Vermont's SIM grant. The SIM Project Director and Project Management Team will use Microsoft Project software to support resource and task tracking, reporting and oversight. A timeline of the major milestones of each initiative as well as staff resource plans can be found in the appendix. Each initiative will be staffed by interdisciplinary teams comprised of a mix of new and existing staff and various levels of contracting support (see section K).

All implementation and evaluation milestones presented in the timelines are based on realistic assessments of both internal and external readiness. The timing of all the activities across the models are designed to:

- align and coordinate with existing federal program milestones (see section B),
- allow for sufficient input from relevant workgroups and the steering committee (see section A),
- ensure multi-payer and provider collaboration
- align with the sequencing of health information technology activities and milestones and reduce administrative burden where possible
- proceed in parallel

While each model requires a tailored approach and cycle based on the task and resource requirements need for successful implementation and evaluation, there are common components to each model, which are color coded in the timelines presented in the appendix. Each of these major components will be used as process-oriented self-evaluation measures to track progress towards implementation and reported on as part of quarterly reporting to CMMI. We expect the process measures selected to report would change over time as Vermont moves along in its timelines.

These components include:

COLOR CODE	COMPONENT OF PROJECT PLAN	PROPOSED INTERIM SELF-EVALUATION PROCESS TRACKING MEASURE
	Staffing of Project Teams	% Open Positions
	Acquisition of Contracting Resources	% Open Consultant Contracts
	Release of Program RFPs and Contracts	% RFPs released by planned date % Contracts Signed by planned date
	CMCS Coordination and Approvals	% Concept Papers Submitted % SPAs Submitted
	Learning Collaborative Launch and Maintenance	% Learning Collaborative Launched
	Workgroup and Steering Committee Consensus	# Workgroup Meetings
	Broad Stakeholder Engagement	# Stakeholder Meetings Held

	Systems Readiness	# Change System Requests (CSRs) Completed
	Programmatic Launch and Maintenance	# Project Milestones met by planned date
	Monitoring and Evaluation Plans and Findings	# M&E Plans Finalized
	Coordination and Alignment Activities	Plan for 2015 Duals ACO Alignment Finalized
	Ensuring Connectivity and Clinical Measurement Capability	Recommendations for Clinical and Connectivity Priorities Adopted by planned date
	Staff Training and Capacity Building; Organizational Change Planning and Management	# of staff trainings on initiatives Post SIM Organization Plan Completed by Date Planned

See Timeline of Milestones through 2016 in the appendix.

Question 39. Are project activities specified/planned in a way that they can complete and produce measurable results during the project's period of performance?

See Timeline of Milestones through 2016 in the appendix and additional description under question #37 above.

Key Artifacts:

Exhibit	Artifact	URL
138	SIM Milestone Timeline (2013-2016)	
106	Medicaid Operational Timelines	
153	Vermont Commercial ACO Pilot - Compilation of Pilot Standards	
128	Proposed Timeline for the Commercial XSSP ACO Implementation	
168	Vermont Proposed Episodes of Care (EOC) Program	
33	Act 50, Section E.307.2 (Reduction in Medicaid Cost Shift)	http://www.leg.state.vt.us/docs/2014/Acts/ACT050.pdf
181	VOP Annual Report	
182	VOP Annual Report Presentation for GMCB	
54	Blueprint 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
53	Blueprint for Health 2011 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint%20Annual%20Report%20Final%2001%2026%2012%20_Final_.pdf
52	Blueprint for Health 2010 Annual Report	http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf
51	Blueprint for Health 2009 Annual Report	http://hcr.vermont.gov/sites/hcr/files/pdfs/BP2009AnnualReport2010_03_29.pdf
28	ACO Measures Work Group Meeting Agendas and Minutes	
29	ACO Standards Work Group Meeting Agendas and Minutes	

Section Q	Communications Management Plans

This section describes how Vermont will engage in a multi-level, cross agency effort to ensure appropriate communications to payers, providers and Vermonters.

Question 40. Describe the state's communication plan to reach the following stakeholders throughout the length of the project:

a) **Payers (public and private)**
b) **Providers and caregivers (including academic medical centers, hospitals, community-based practices, specialists/behavioral health, long-term care)**
c) **Public health organizations (DOH, CDC, etc.)**
d) **Social services (transportation, education, nutrition, housing)**
e) **Patients and their families**

The State of Vermont's updated Stakeholder Engagement Plan describes each of the stakeholder groups that are instrumental to the implementation of the activities described in this Operational Plan. The Stakeholder Engagement Plan also describes the materials that have been and will be developed to support communications with each of the stakeholder groups and details the meeting schedule for each.

Vermont has a history of actively engaging stakeholders in its health reform initiatives and health system governance, and the state will leverage the expertise of existing advisory bodies to inform the implementation of the State Innovation Model (SIM). In addition to engaging Vermont's existing and diverse stakeholder groups, the state has created or reconstituted several additional work groups to address specific SIM tasks: Payment Models, Quality and Performance Measures, Care Models and Care Management, Health Information Exchange, Workforce Steering Committee, and Population Health. In particular, the Payment Models and Quality and Performance Measures work groups have been reconstituted for the SIM project but have already accomplished significant tasks relative to the aims of SIM.

The SIM Project Director will be responsible for directing communications about SIM project to the variety of stakeholder groups and will be supported in doing so by the SIM Stakeholder Engagement Coordinator at the Green Mountain Care Board. The information about the SIM project will be shared with stakeholder groups in a manner that is consistent with the existing

stakeholder engagement plans for these entities. In addition, external stakeholders will serve as co-chairs of each of the work groups contemplated as part of the SIM/Duals project. Vermont expects that the groups it has identified as essential to the SIM work will continue to operate throughout the grant period and well beyond.

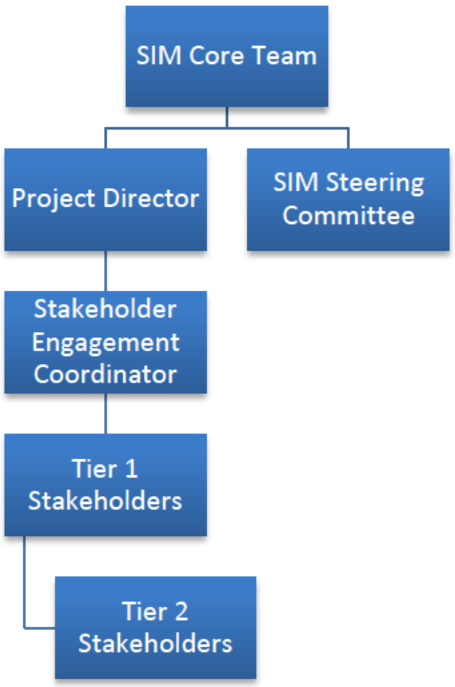
Question 41. Demonstration that the state has initiated external communications with each group of relevant stakeholders including:

a) Payers (public and private)
b) Providers and caregivers (including academic medical centers, hospitals, community-based practices, specialists/behavioral health, long-term care)
c) Public health organizations (DOH, CDC, etc)
d) Social services (transportation, education, nutrition, housing)
Patients and their families

The SIM Project Director, supported by the SIM Stakeholder Engagement Coordinator (located at the GMCB), will be responsible for overseeing and managing communications to the stakeholder groups that have been regularly meeting, and to those groups that will be formed. Outreach to multiple stakeholder groups has already been initiated and these groups have been activated in their capacity as advisory bodies for the SIM grant. As explained in the Stakeholder Engagement Plan, each state agency involved with the project has associated with it a number of stakeholder groups that provide input on a wide range of topics. Likewise, private payers and providers represented on the Stakeholder Engagement Plan have additional stakeholders that they communicate with about a variety of issues.

In order to manage communications with all stakeholder groups, the SIM Project Director will be responsible for communicating about grant activities to the first tier of stakeholders representing partner state agencies and partnering providers and payers. The first tier of stakeholders will then be responsible for communicating to their stakeholders, or the second tier, about the grant activities. First tier stakeholders will be expected to leverage the second tier stakeholders when their input is pertinent to a particular topic. The Project Director will also be responsible for communicating information from stakeholders to the SIM Engagement Coordinator who will work with the SIM Work Groups to implement and incorporate the feedback and information from stakeholders. The Project Director will be responsible for communicating with the staff and chairs of the SIM Workgroups to monitor their progress and structure appropriate reporting to the Steering Committee and Core Team.

SIM Stakeholder Engagement Structure



The SIM Stakeholder Engagement Coordinator will be responsible for tracking stakeholder engagement through scheduling project staff to brief key groups, collecting meeting minutes, materials, participation in webinars or other online learning forums, and management of the Stakeholder Engagement Plan Group Membership (see Appendix). Communications that have already been initiated with Stakeholder groups are described in the list of "key artifacts" below.

In both the Updated Stakeholder Engagement Plan and in Section H of the Operational Plan, there are detailed descriptions of stakeholder groups and the ways in which they are communicated with. Consistent communications with the stakeholder groups, including providers and payers, is an essential component of the retention strategy described in Section H.

Vermont will create a timeline outlining key communication events related to the SIM initiative and the timeline for implementation of the payment models. The communications timeline will be completed after the timeline for model implementation is approved by the Steering Committee and the Core Team.

Question 42. Who is the entity overseeing and executing all components of the communications plan across the entire grant period?

The SIM Project Structure identifies the SIM Project Director as a position that reports to the SIM Core Team and works directly with the SIM Government Operations Team. The SIM Project Director has been designated as the entity that will be responsible for the communications plan, assisted by the Stakeholder Engagement Coordinator.

Key Artifacts:

Exhibit	Artifact	URL
144	Stakeholder Engagement Plan	
141	SIM Stakeholder Meeting Schedule	
	Meeting Minutes:	
83	GMCB Mental Health Substance Abuse TAG Meeting Minutes (5 15 13)	http://gmcboard.vermont.gov/sites/gmcboard/files/MHSA_TAG051513.pdf
80	GMCB Health Care Professional Technical Advisory Group Minutes (6 5 13)	http://gmcboard.vermont.gov/sites/gmcboard/files/HCPTAG_MINUTES060513.pdf
75	GMCB ACO Patient Experience Survey Subgroup Meeting Summary	
104	Medicaid and Exchange Advisory Board Meeting Agendas and Minutes	http://healthconnect.vermont.gov/advisory_board/meeting_materials
	Meeting Materials:	
105	Medicaid and Exchange Advisory Board SIM Presentation	
142	SIM Steering Committee Initial Presentation	
	Communications Plans	
84	GMCB Outreach and Engagement Plan	
154	Vermont Health Connect Education and Outreach Plan	
135	SIM Engagement Coordinator Scope of Work	

Section R	Evaluation Plan

This section describes Vermont's efforts to date regarding developing an Evaluation Plan for the SIM project. Vermont has experience in designing and implementing evidence-based evaluation frameworks, most recently as part of the MAPCP program.

Question 43: Has the state contracted with an entity for managing data collection and reporting processes (self-evaluation, reporting to CMMI, and financial data for multi-payer systems)?

Question 44: Has the State designed, planned and implemented an evidence-based evaluation framework to measure the progress and outcomes of the planned transformation?

Question 45: Has the State designed, planned and started to implement a meaningful self-evaluation and continuous improvement monitoring for the planned transformation?

The major goal of evaluation is learning and adjusting processes to maximize the project's stated goals. Learning occurs when evaluation provides information that enables current decision-making and guides future application of intervention (model) tested. It is, therefore, important for the evaluation design to include sufficient rigor so that relatively firm conclusions can be reached by project end. Evaluation will also provide a feedback loop that supports internal learning and facilitates stakeholder engagement. Vermont's SIM Project includes staffing for an Evaluation Director. This person will be responsible for coordinating all of the SIM Project's evaluation efforts. We anticipate hiring this person in late Summer 2013 through the GMCB.

The State of Vermont will be contracting with an entity to design, plan and implement an evidence-based evaluation framework. The state released an RFP in July, 2013 and hopes to select a vendor by September 2013. Evaluation planning will occur concurrently with project planning. This vendor will be responsible for overall SIM project evaluation as well as evaluation of specific models being tested. The vendor will also work with the federal evaluation team to ensure data are shared and we do not unnecessarily duplicate efforts.

Vermont, with its selected evaluation vendor, will use a stakeholder consensus process to identify measures that are appropriate to our goals. These measures will directly connect with the Driver Diagram and the models being tested across the state. The vendor will be helpful in designing methodology and processes, while the state will guide the collection of information necessary to measure the impact.

Vermont is leveraging the surveillance and analysis work done through the Department of Health to develop population health measures. We also have received technical assistance support from the National Governors' Association to enhance our population health work. We will also maximize the technical assistance support offered by the CMMI technical assistance team to ensure a well-balanced set of measures. One challenge to the evaluation of this project will be to separate the effects of the multiple interventions underway in Vermont that could have an impact on health care and health outcomes. Our contractor will work with us to address this issue. Additionally, the contactor will assist us in developing appropriate comparison groups for Vermont. A similar effort has been undertaken for the Blueprint for Health, with development of matched cohorts from outside the state.

As described in Section I of this Operational Plan, Vermont will use several SIM work groups to assist in developing performance measures. This work will both strengthen Vermont's data collection and provide consensus built measures for evaluation. The evaluation plan will utilize the state's data systems, described in sections D and E of the Operational Plan. We are also committed to improving these data systems as the system transforms and we identify new data needs. The state's data system improvement process is described in Sections D and E as well.

Vermont has developed the following process for ensuring we are engaged in a critical self-improvement effort:

1. The state will use the quarterly reports submitted to CMMI as an opportunity to critically review our progress towards the SIM Project goals.

2. We will utilize the SIM Steering Committee to gather input on the project. We will provide the Steering Committee with quarterly reports showing project goals and progress and seek their input on identifying areas for focused continuous improvement.

3. We will also use the SIM Work Groups to identify areas for process and SIM Project improvement. The Work Groups will focus the efforts identified in each of their respective Charters.

4. We are required to report on SIM progress to the Legislature throughout the year. These updates will also ensure that the Project is progressing and that all stakeholders have had opportunity to participate in its improvement.

Key Artifacts:

Exhibit	Artifact	URL
136	SIM Evaluation RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/REVISED_SIM_RWJF_EvalRFP2.pdf
137	SIM Evaluation RFP Q&A	http://gmcboard.vermont.gov/sites/gmcboard/files/EVALSIM_%20RFP_Q%26A.pdf
54	Blueprint for Health 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
	Health Department reports on population health measures	
96	Healthy Vermonters 2020	http://healthvermont.gov/hv2020/documents/hv2020_report_full_book.pdf
94	Health Status of Vermonters (2008)	http://healthvermont.gov/pubs/documents/HealthStatusRpt2008.pdf
95	Health Status of Vermonters (2008) Appendix	http://healthvermont.gov/pubs/documents/HealthStatusRpt2008_appendix.pdf
90	Health and Healthcare Trends in Vermont (2010)	http://healthvermont.gov/research/documents/health_trends_vt_2010.pdf
131	Rule H 2009-03 Evaluation of the 2012 Managed Care Organization Data Filings	http://www.dfr.vermont.gov/sites/default/files/2012_Rule9-03_DataFilingRp.pdf
97	Hospital Community Reports (Act 53 Reporting) - Vermont DFR Website	http://www.dfr.vermont.gov/health-care/hospitals-health-care-practitioners/2011-hospital-report-card
150	VDH Population Health Measure Collection and Use	
	Outcome Measures	
117	Outcome Measure Selection from Suggested CMS Core Measures List	
116	Outcome Measure Selection - ACO Payment or ACO Monitoring	
118	Outcome Measure Selection - Health System Monitoring or Pending Status	

Section S Fraud and Abuse Prevention, Detection and Correction

This section discusses Vermont's efforts to prevent fraud and abuse in the current reimbursement structure and how we will leverage that work to guard against future fraud and abuse.

Question 46. Has the State integrated sufficient protections into the planned transformation to guard against new fraud and abuse exposures introduced under new payment models?

The State recognizes the critical importance of preventing fraud and abuse (F&A), under current practice and as part of the State's transformation. As a result, the State has built practices and structures to protect its current reimbursement structure, and which will be leveraged to prevent F&A under new payment models.

First, as part of the provider enrollment process, Medicaid requires providers to maintain clinical documentation sufficient to support payment for services. The majority of payment models proposed under the grant require continued detailed submission of claims data so the methods used to prevent against F&A will remain relevant and useful tools to guard against F&A under new payment models. Moreover, as the new models increasingly rely on the use of additional clinical data from the state's clinical registry, it will be subject to the same standards of documentation. Therefore, the same tools can be extended for use with this new, evolving source of data as it is used to make payment adjustments. Additionally, all contracts with providers for new payment arrangements will include fraud and abuse protections, penalties, and performance-based terms and conditions.

Further, as the State moves forward with new payment models, it will also leverage the existing F&A structures and practices in place at the Vermont Attorney General's Office's Medicaid Fraud and Residential Abuse Unit (MFRAU), one of fifty Medicaid Fraud Control Units (MFCUs) nationwide that receive federal funding from HHS-OIG to investigate and prosecute fraud by Medicaid providers, and abuse/neglect of individuals in room-and-board facilities. Over the

past three years, MFRAU has recouped more than $16 Million in state and federal funds, obtained more than two dozen criminal convictions, and processed almost 700 complaints. The unit has also performed significant training and outreach activities to both the provider and enforcement communities. These activities are described in more detail in MFRAU's annual reports. *See* 2012 & 2013 Annual Reports, attached.

In addition, MFRAU, jointly with the Program Integrity Unit at DVHA and the United States Attorney's Office (USAO), created the Vermont Healthcare Fraud Enforcement Task Force in late 2011. The Task Force, comprising representatives from MFRAU, the USAO, OIG, FBI, and others, meets quarterly to discuss cases and potential referrals and holds an annual meeting each May or June. The Task Force's objectives are to:

(1) improve collaboration and coordination of civil and criminal healthcare fraud cases among Vermont state and federal agencies;
(2) identify trends in Vermont healthcare fraud;
(3) share and leverage resources; and
(4) develop new fraud enforcement tools and resources.

This year's program focused on four successful fraud prosecutions, and identified specific program recommendations and strategies for identifying similar types of fraud going forward. *See, e.g.,* Attached presentations from 2013 Annual Meeting. *See also* MFRAU 2012 Annual Report at 7. MFRAU is now in the process of forming a working group with various Vermont state agencies to refine program recommendations introduced at the June 2013 annual meeting regarding fraud in Vermont's home health/PCS Medicaid programs.

One area where the State plans to improve its fraud and abuse protections involves the use of non-service related payments (e.g., capacity payments). The payments are not service level payments and instead are used for the hiring of specific staff to perform a range of specified services across a given patient population. It is expected that the clinical registry and financial reports will be the primary data source to ensure program integrity related to these payments. As this model is one of the most innovative proposed (contained within the duals model of care, health homes and existing MAPCP), the State will need to continue to refine and adapt its tools and resources to fully protect against F&A. Elements of the evaluation and monitoring plan will focus on assessing and improving program integrity around this payment model.

Question 47. Has the State addressed existing fraud and abuse protections that may pose barriers to implementing the proposed innovation model and have necessary waivers been obtained from OIG/Medicare?

Given the continued use of detailed claims and clinical data underlying all the models and current models in place under the state's Medicaid waivers, the State has not identified any barriers to implementation of the proposed innovation model related to existing fraud and abuse protections. As part of the planning process and in coordination with Medicaid program integrity staff as well as the SIM technical assistance contractor Manatt Health, the state will continue to work towards identification of whether waivers not yet anticipated are needed. Also, building protections against fraud and abuse will be included in the monitoring and evaluation plans supporting each model. Given the phased nature of the payment model implementation, the State believes there is sufficient time to continue to assess needs for any additional waivers.

Key Artifacts:

Exhibit	Artifact	URL
109	MFRAU 2012 Annual Report (July 1, 2011 — June 30, 2012)	
108	MFRAU 2011 Annual Report (July 1, 2010 — June 30, 2011)	
126	Powerpoint Presentation from Vermont Healthcare Fraud Enforcement Task Force 2013 Annual meeting entitled "Fraud in the Vermont Medicaid Program's Home and Community Based Waiver Programs: A Case Study" (June 11, 2013)	
127	Powerpoint Presentation from Vermont Healthcare Fraud Enforcement Task Force 2013 Annual meeting entitled "State of Vermont v. McGRX, Inc." (June 11, 2013)	
21	33 V.S.A. § 141	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=001&Section=00141
22	33 V.S.A. § 143	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=001&Section=00143
23	33 V.S.A. § 143a	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=001&Section=00143a

Section T	Risk Mitigation Strategies

Vermont has identified several risks involved in this project. As indicated below, we have also developed strategies for mitigating those risks. We also anticipate the need to revise this risk/mitigation list over time as we implement the payment models in the SIM Project.

Question 48. Has the State conducted a thorough study of the likelihood of success and the potential risk factors that must be addressed to increase the probability of success of the proposed innovation model, including recommendations for mitigating identified risks?

Question 49. Has the State planned and implemented a process for managing and mitigating risks over the course of the proposed transformation project?

Operational Plan Section	Risk	Mitigation
All	Project complexity: this is a large and complex project, by necessity involving many people and organizations within and outside state government. We anticipate implementing multiple complex models and interventions, with the need for significant coordination across efforts.	We have designed our project governance and management structures to provide for shared decision-making among project participants, open communication and a formal structure that will foster both clear assignment of tasks and accountabilities, and coordination between discrete project components through project leadership.
All	Loss of federal funding	Vermont is committed to the work described in our SIM Project, and we were pursuing an agenda of payment and delivery system reform prior to the SIM grant award. If, however, we should lose the SIM funding, the activities described in this plan would be scaled back and decelerated. We also expect that providers and payers would need more time to transform their practices without

		the information infrastructure and other tools provided with SIM funding.
All	Contract procurement delays	Despite planning, contracts can be delayed. Vermont will provide as much information as possible in RFPs to avoid delays and contractor confusion. We will also go over the contracting plan with the purchasing and contracting departments and legal offices so that all state entities involved in the process understand the timelines.
All	Departure of key personnel	As with any large project, certain personnel are beneficial to the overall project success. The skills and abilities of the growing SIM team were selected to enable the SIM Project's success. However, the Project does not rely on any one individual, but rather a team. We expect that should any member of the team depart, we would be able to recruit a replacement and the rest of the team would reconfigure as necessary to accomplish the SIM Project.
All	Adherence to project timelines and milestones	Vermont's timeline is aggressive. At this time, we believe we have developed the relationships and the processes to adhere to this timeline. We will utilize the SIM Project's management structure, contracted project managers and the CMMI reporting structure to develop a detailed project deliverable timeline to ensure we meet project milestones.
C and Q	Providers, individuals and payers do not participate in the SIM Project	At this time, we have achieved significant payer and provider participation in the SIM Project. We do not expect this to

		change and have modified our governance structure to include more private section decision-making. We expect this enhanced role for providers, payers and individuals will enable us to work through any issues that might lead to a lack of participation. We will also design our communications to be relevant, timely, clear, predictable, appealing and multi-modal to assure communication with payers, providers and individuals.
B, G and P	Payment and delivery models implemented through the project do not achieve the desired outcomes due to weak, poorly specified or misaligned incentives	We will test and evaluate the models implemented through this project both through formal, retrospective analysis and through real-time testing of our assumptions about incentives, causation and likely outcomes with project participants and stakeholders
D	The exchange of clinical information between providers benefits delivery of care, usually resulting in more appropriate care and utilization. However, an increase in the number of information transitions increases the risk of data gaps.	We will utilize and expand upon the extensive health information exchange network built in Vermont to date and leverage the experience of organizations well-grounded in HIE build-out. In addition, through the project we will seek to reduce the complexity of IT infrastructure development and coordinate across the multiple organizations involved to leverage the best thinking about and design of our HIT enhancements.
D	Data used in SIM is in various formats and locations. This can cause communications challenges and unnecessary project delays.	We will use Vermont's HIT Plan as a guide for consistent data sharing and we will revisit the HIT Plan at least once per year to ensure data are flowing according to the Plan.

D and J	Privacy and confidentiality of private data	• Continue current policy of protecting data • Revisit policies annually to ensure privacy and confidentiality of the data
E	Sustainability of HIT investments- both state and federal.	The state committed to developing a strong HIT infrastructure in 2004 and continues to support this work.
K	Inability to recruit SIM Project staff	Due to the specialized skills and small population and rural predominance of the state, timely recruitment of qualified staff is an identified challenge and the SIM leadership and operations staff are closely monitoring and putting resources towards these efforts.
L	Providers and other entities do not participate in the Workforce Workgroup or otherwise do not actively engage in the State's workforce discussions.	Should entities not actively participate in these specific planning vehicles, we will identify alternative means to engage key constituencies.
M	Providers will not engage in quality improvement and care transformation activities.	Vermont has a long history of successful implementation of quality improvement initiatives. Many of these are provider driven and those identified in the SIM Project are built off of the existing improvement infrastructure.
R	Insufficient rigor in evaluation design to draw conclusions.	Vermont is currently procuring an independent evaluator. To ensure the independent evaluation is sufficient, we will hire a reputable vendor with experience in this area.
R	Distinguishing the impact of any	Vermont is currently procuring an

	particular innovation or initiative from the gross outcome changes in the system.	independent evaluator. To ensure the independent evaluation is sufficient, we will hire a reputable vendor with experience in this area.
S	Identification of the need for a waiver from the Federal Government that is not currently anticipated	At this time, Vermont does not anticipate needing any waivers. However, the need could arise in the future. Should we identify this need, we will work with our federal partners to obtain the waiver as soon as possible and with minimal disruption to the project.
S	There are many existing federal and state laws to guard against fraud and abuse. These laws were not necessarily designed with the new payment models in mind and the existing protections could provide obstacles to implementing new payment models.	Vermont has not identified any legal obstacles in the existing fraud and abuse laws. We have had one conversation with federal experts in this area and will continue the conversation with them during model testing to ensure we have properly assessed these legal issues.